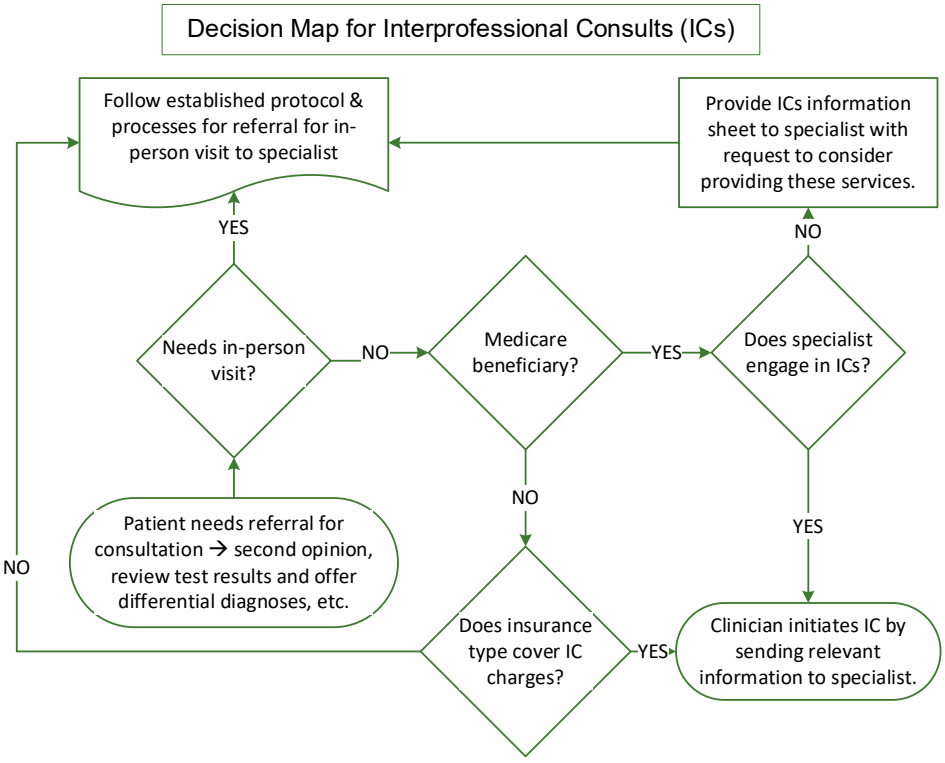
Interprofessional Consultation: A Patient-Centered Referral Option

Introduction

Many clinicians are not aware of the option for interprofessional consultations – either to request a consult or to perform a consult. According to the Centers for Medicare & Medicaid Services (CMS) "…these inter-professional consults are typically initiated by a primary care practitioner to a specialist for a low acuity, condition-specific question that can be answered without an in-person visit."[1] There are five billing codes for the consultant and one billing code for the treating/requesting physician or other qualified health care professional. Having the coding and approximate reimbursement amounts can be helpful to have when talking to specialists about this opportunity. Medicare does not reimburse clinicians at Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) for these codes. However, partnering with specialists that will conduct interprofessional consults can expand access and be convenient for patients, especially if it saves them a trip to see a specialist in person.



[1] Calendar Year 2021 Physician Fee Schedule Final Rule p. 84587.

Table 1. Interprofessional consultation service details, codes and prices.

SERVICE DETAILS	CODE - PRICE
Interprofessional telephone/internet/electronic health record assessment and management service provided **by a consultative physician**, including **a verbal and written report** to the patient's treating/requesting physician or other qualified health care professional	99446 (5-10 min): $19 99447 (11-20 min): $34 99448 (21-30 min: $54 99449 (≥ 31 min): $73
Interprofessional telephone/internet/electronic health record assessment and management service provided **by a consultative physician**, including **a written report** to the patient's treating/requesting physician or other qualified health care professional, five minutes or more of medical consultative time	99451 (≥ 5 min): $36
Interprofessional telephone/internet/electronic health record referral service(s) provided **by a treating/requesting physician or other qualified health care professional**, 30 minutes	99452 (≥ 16 min): $37
National payment amount for the non-facility price from the Physician Fee Schedule Search as of June 18, 2021, rounded to the nearest dollar. Do not rely on these. Have your biller/coder double-check.	

Consultant codes 99446-99449 and 99451

May be reported:

- For new or established patients
- For new or existing exacerbated problems
- If the following is documented in the record
    - Request and reason for the request for the consult
    - Verbal consent for the interprofessional consultation from the patient/family
- Only when requested by another clinician
- Only once per seven days for the same patient
- Only if the patient was not seen by the consultant within the past 14 days
- Only if a transfer of care or request for a face-to-face consult does not occur as a result of the consultation within the next 14 days
- Based on cumulative time spent, even if that time occurs on subsequent days

Codes 99446-99449

- 50% of the time reported must be devoted to the medical consultative verbal or Internet discussion rather than the time needed for data review and/or analysis
- Verbal opinion *and* written report must be submitted to the requesting clinician

Code 99451

- The 50% rule does not apply. Time is based on total review and interprofessional communication time.
- Only written report must be submitted to the requesting clinician

Requesting clinician code 99452

May be reported:

- To capture 16-30 minutes preparing for the referral and/or communicating with the consultant
- Only by clinicians who can independently bill Medicare for Evaluation & Management (E/M) services
- By the requesting clinician who is treating the patient and has requested the non-face-to-face consult for medical advice or opinion and *not* for a transfer of care or face-to-face consult
- Only when the patient is not on-site and with the clinician at the time of the consultation
- Only if not reported more than once per 14 days (per patient)
- To include time preparing for the referral and/or communicating with the consultant
- Only if a minimum of 16 minutes is spent
- With prolonged services, non-direct → check the most current official CPT codebook for additional details

The written or verbal request by the treating/requesting clinician should be documented in the patient's medical record, including the reason for the request.