



Society for
Maternal • Fetal
Medicine

Coding for Telehealth & Remote Services in the MFM Outpatient Setting- Tele, Audio, Online, Digital Health



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Telehealth & Remote Services in the MFM Outpatient Setting



- In the current (post) pandemic era, telehealth and remote monitoring services are essential tools for caring for pregnant women
- Anticipated to continue to play an integral role in the future of healthcare
- Benefits include
 - Increase access to specialty care
 - Reduced patient costs
 - Reduced travel burden
 - Require less time for all parties
 - Allow improved reimbursement, patient education, and satisfaction
 - Services are not limited to physicians only
 - Key during the pandemic era but also after
 - Some services do NOT require face-face interaction



Telehealth & Remote Services in the MFM Outpatient Setting



- Cumulatively enhance delivery of much needed MFM services
- Newer, recent CPT codes have become available to provide additional opportunities for remote monitoring of patient health data and reimbursement via Audio, Online, and Digital Health
- SMFM Coding Committee has shared detailed guidance on coding for telemedicine and remote patient monitoring services in the past
 - **Would like to share those available codes that may be of clinical utility for MFM sub-specialists**
- Discussion of set up and nuances of telehealth and remote monitoring services are out of the scope of today's presentation



Types of Telehealth



- Telehealth refers to a broader scope of remote services than telemedicine and is a collection of means or methods for enhancing health care or health education using telecommunications technologies
- Telehealth services comprise 3 components- clinical care, technology support, and administration
- Telemedicine is the delivery of medical care or services from a distant site and involves real-time interactive audiovisual communication between a patient and healthcare provider



Types of Telehealth



Types of telehealth modalities include:

- **Live, two-way or real-time synchronous audio and video:** Provider and patient communicate in real-time (as if in the same room) to discuss conditions but not in the same location.
- **Store-and-forward, aka asynchronous telemedicine:** Information (eg, ultrasound recordings) is captured from patient at one time and location, and evaluated by a provider at another time and location.
- **Hybrid consultation:** Blends synchronous and store-and-forward modalities.
- **Remote patient monitoring (RPM):** Collects personal health and medical data (eg, blood glucose, blood pressure) from one location and electronically transmits the data using medically designated devices or smartphone applications to a physician in a different location for use in clinical care.




Synchronous



- Telemedicine services are live videoconference consultations where a physician and the patient communicate in real-time **face-to-face** but are not in the same geographic location
- Issues to consider: Equipment, IT, state medical board requirements, malpractice insurance, credentialing and privileging, reimbursement, security, integration with EMR, state laws, etc.



Synchronous

-  Telemedicine consultations require the same elements as those required in regular face-to-face consultations and E/M billing:
 - (1) Request for consultation; (2) Opinion; (3) Written Report
- Currently relevant CPT codes for maternal-fetal medicine subspecialists would include the following E/M series:
 - 99201-99215 office outpatient
 - 99241-99245 outpatient consultation
 - 99212-99215 outpatient follow up
 - 99251-99255 initial inpatient
 - 99231-99233 subsequent inpatient



Synchronous

- The communication of information exchanged during the course of the synchronous telemedicine service must be sufficient to meet the same key components and/or requirements of the CPT when rendered face-to-face with patients (refer to latest E/M guidelines; clearly documented)
- **In order to bill for these services**
 - Place of Service (POS) Code 2 is used to specify health services and health related services provided or received, through a telecommunication system
 - Modifier -95 is appended to the appropriate E/M CPT code: Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System
 - Modifier -25 is applicable when significant, separately identifiable evaluation and management service is performed by the same physician on the same day of a procedure or other service (eg, ultrasound)
- Check with individual payers for reimbursement policies regarding these codes (as well as any alternative or additional codes they may request to be used). Please also consult with your biller to ensure these recommendations are followed. Patients remain responsible for co-pay, deductible, and co-insurance patient share fees per their individual plans



Store-and-forward / Asynchronous

- **Store-and-forward, aka asynchronous telemedicine:** Information (eg, ultrasound recordings) is captured from patient at one time and location, and evaluated by a provider at another time and location.
- Most but not all ultrasound procedures fall under the general supervision category and could be read remotely if local arrangements are made to inform the patient of her ultrasound results
- All components of the CPT study are included and the appropriate indications are used
- Appropriate and complete report should be generated and sent to referring provider
- Relaying results of a normal study to the patient are part of the RVU work associated with the CPT so there should be a mechanism in place to relay findings to patient



Store-and-forward / Asynchronous

- While test results are not required to be conveyed to the patient in person, because of the expertise required for some scans, best practice is to have a physician available to discuss results with the patient.
- Informing patient of normal results is part of the CPT work associated with the ultrasound procedure and a separate E/M service cannot be billed to convey normal results (whether done in person or via telemedicine).
- **Hybrid**: E/M services done same day for counseling regarding abnormal results or a separate indicated consultation, may be billed in addition to the ultrasound procedure as long as all E/M criteria have been met and documented. (Modifier 25, Modifier 95, POS 2)
- When reading studies remotely, use of modifier 26 (professional component), TC (technical component), and 25 still apply.



RPM Introduction Example



- Patient A is being monitored for gestational diabetes. She is 32 weeks pregnant. She checks her blood glucose several times a day. She is using an FDA approved device which electronically transmits her blood glucose readings to your office, which was initially set up by an outside diabetes educator. In the past 30 days, the clinical staff and MFM Dr. X in your office have spent 45 minutes of time reviewing patient A's blood glucose levels and communicating with her via phone and email about her diabetes management.

Recommended coding: 99457, 99458. (Total Time 45 minutes)



Remote Physiological Monitoring Treatment and Management Services



- Newer CPT codes became available in 2019-2021 to expand and provide additional opportunities for remote monitoring of patient health and reimbursement as a way to continue to help providers respond to the growing shift and demand for virtual care services



Remote Physiological Monitoring Treatment and Management Services



- These newer codes involve using a device to track a patient's important health metrics, such as weight, blood glucose, blood pressure, respiratory flow rate, and pulse oximetry
- These services are distinct from telehealth services and do not require face-to-face interaction though patients are expected (previously) to be established patients seen by practitioner face-to-face within 1 year prior



Remote Physiological Monitoring Treatment and Management Services



- During the pandemic, Medicare began to cover these services for both new and established patients, for both acute and chronic conditions, and for patients with only 1 disease
- Private payers continue to update their policies and some have followed suit
 - It is recommended to check with each payer's most updated policy changes in relation to the billing and coding for telehealth and remote services especially during the pandemic era and afterwards (...)
- Patient consent and cost-sharing such as deductibles, co-payments, co-insurance still apply in the case of these codes



Remote Physiological Monitoring Treatment and Management Services



- RPM treatment management services are provided when clinical staff, physician, and or other qualified health care professionals (QHP) use the results of remote physiological monitoring to manage a patient under a specific treatment plan
- To report RPM, the device used should be a medical device as defined by the FDA (loose definitions), and the service must be ordered by a physician/QHP. Data from those devices must be collected and transmitted electronically, ie, no patient reported data is allowed.



Remote Physiological Monitoring Treatment and Management Services



- Some of these CPT codes (99457, 99458) require an interactive communication with the patient/caregiver but not all codes require interactive communication
- For all RPM services, you **may not** count any time towards remote monitoring on a day when the physician/QHP reports E&M services- office or other outpatient services, inpatient services, rest home services or home services
- As always, proper documentation of services rendered, medical necessity, and copy of all records and data transmitted must be saved on chart
- Patients must provide consent for RPM services which needs to be clearly documented in the medical record
- May set up by yourself in your office or use one of many commercial products and services



Description of RPM CPT Codes



- **99453: One-time practice expense reimbursing for the setup and patient education on RPM equipment. This code covers the initial setup of devices, training and education on the use of monitoring equipment, and any services needed to enroll the patient on-site.**
 - Initial Setup of Device. Remote monitoring of physiologic parameter(s), initial set-up and patient education on the use of monitoring equipment. Billed one time at set-up, onboarding, only first month of reading. Initial setup must be ordered by physician/QHP. (~\$19 CMS Reimbursement)
- **99454: Used for the monthly remote monitoring of physiological parameters, and covers the supply of the devices used by patients to monitor and record physiologic data**
 - Supply and Provision of Devices. Device Supply with Daily Recordings and Programmed Alerts. Remote monitoring of physiologic parameter(s), initial; device(s) supply with daily recordings(s) or programmed alert(s) transmission, billed each/once in 30 days. Requires minimum 16 days or more of monitoring (~\$64)
 - **Notably, CPT Code 99454 requires at least 16 days of device readings submitted by the patient within the 30-day period. Meaning, to receive reimbursement, the physician must have at least 16 days worth of readings from the patient.**
 - The device used in the program must be a home-use medical device as defined by the FDA. Home-use medical devices can be used daily to monitor the patient's physiologic data and automatically uploaded to a clinician remotely.
 - The physician or QHP must order the devices on behalf of the patient.



Description of RPM CPT Codes



- **99457: Designed to provide reimbursement for care coordination and physician-patient interaction; at least 20 Minutes of Monitoring and Treatment Management That Includes Interactive Communication with the Patient/Caregiver During the Calendar Month**
 - Remote physiological monitoring treatment management services, clinical staff/physician/other QHP time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes in the month.
- The code can be reported once in 30 days, regardless of the number of parameters monitored. (~\$51)
- Cannot be reported for services of less than 20 minutes.
- **Note that clinical staff time contributes towards monitoring and interactive virtual communication may also include phone, text, and email, or other electronic non-face-to-face communication/interaction.**
- Providers should include all notes and documentation of all information as possible (eg, device interrogations, calls made to the patient and their duration, time reviewing data, interaction with patient records, etc). Consent for services is required and to be documented accordingly in the patient's record.



Description of RPM CPT Codes



- 99458: Each additional 20 minutes of Monitoring and Treatment Management Services Provided. Once per calendar month.
 - Must be listed separately and reported in conjunction with 99457. (~\$42)



Self-Measured Blood Pressure or SMBP



- There are 2 newer CPT codes for Self-Measured Blood Pressure (SMBP) refers to blood pressure (BP) measurements obtained outside a physician's practice, usually at home
 - Join existing CPT codes for remote monitoring, but these are based on the patient's self-measurement and reporting.
 - The first is patient education and calibration of a home blood pressure device.
 - The second is for reviewing data collected by the patient at home, with a report and communication back to the patient.



Description of RPM CPT Codes



- The SMBP measurements Data collection/report is used for SMBP data collection and interpretation when patients use a BP measurement device validated for clinical accuracy to measure their BP twice daily.
- The SMBP measurements must be communicated back to the practice and can be manually recorded or electronically captured and transmitted.
- The physician/QHP must then create or modify the treatment plan based on the documented average of these readings. The treatment plan must be documented in the medical record and communicated back to the patient, either directly or through clinical staff.



Description of RPM CPT Codes



- 99473: Training/calibration. Used when patient receives education and training on the set-up and use of a SMBP measurement device validated for clinical accuracy, including device calibration. Reported once per device.
 - Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration. Report once per device.



Description of RPM CPT Codes



- 99474: Separate self-measurements of two blood pressure readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient or caregiver to the physician/QHP, with report of average blood pressures and subsequent communication of a treatment plan to the patient.
 - Note: This code can be reported once per calendar month only. 99473 and 99474 should not be reported in the same calendar month as RPM monitoring codes 99091 (older code) and 99457.
 - 99473 and 99474 should not be reported if performed as part of an E&M service. A separately reportable E&M service should be provided with Modifier 25, if applicable.



RPM Example Scenario

Self-Measured Blood Pressure



- Patient B has pre-existing chronic hypertension. She is 22 weeks pregnant. You would like for her to do home BP monitoring. She comes to the office with a new BP machine which she plans to use at home. She receives education and training on accurate BP ascertainment at home. You make sure the device is calibrated and validated for accuracy. She understands and agrees to be compliant with home monitoring.

Recommended coding: 99473. However, if an E/M code is utilized during this visit, then do NOT bill the 99473 (as the calibration is included in the E/M).

- Over the next 30 days, she checks her BP at home twice daily and takes record. She shares this information with you, her MFM for review. You review the blood pressures and communicate with Patient B regarding her treatment plan going forward.

Recommended coding: 99474.



Remote Physiological Monitoring Treatment and Management Services



- 99091: Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient to the physician/QHP, requiring a minimum of 30 minutes of time, each 30 days.
- Please note: This is an older code with limitations; the new RPM codes to follow more accurately reflect services being performed and may be preferred. May not report the use of clinical staff.



RPM Example Scenarios



- Patient A is being monitored for gestational diabetes. She is 32 weeks pregnant. She checks her blood glucose several times a day. She is using an FDA approved device which electronically transmits her blood glucose readings to your office, which was initially set up by an outside diabetes educator. In the past 30 days, the clinical staff and MFM Dr. X in your office have spent 45 minutes of time reviewing patient A's blood glucose levels and communicating with her via phone and email about her diabetes management.

Recommended coding: 99457, 99458. (Total Time 45 minutes)



RPM Example Scenarios



- Patient B has pre-existing chronic hypertension. She is 22 weeks pregnant. You would like for her to do home BP monitoring. She comes to the office with a new BP machine which she plans to use at home. She receives education and training on accurate BP ascertainment at home. You make sure the device is calibrated and validated for accuracy. She understands and agrees to be compliant with home monitoring.

Recommended coding: 99473. However, if an E/M code is utilized during this visit, then do NOT bill the 99473 (as the calibration is included in the E/M).

- Over the next 30 days, she checks her BP at home twice daily and takes record. She shares this information with you, her MFM for review. You review the blood pressures and communicate with Patient B regarding her treatment plan going forward.

Recommended coding: 99474.



RPM Example Scenarios



- Patient C is postpartum. She delivered a 32 week infant, 3 days ago due to pre-eclampsia with severe features. She has PP hypertension and is advised to do home BP monitoring and take Labetalol 3 times a day. She receives a BP machine including education and training on accurate BP ascertainment at home by your office staff/QHP. The device is calibrated and validated for accuracy.

Recommended coding: 99473.

- Over the next 30 days, she checks her BP at home four times daily and takes record. She shares this information with MFM Dr. YZ. Dr. YZ provides her a treatment plan and helps titrate her antihypertensive therapy.

Recommended coding: 99474.



Online Digital Evaluation and Management (99421-99423; 98970-98972)



- Online services are new 2020 time-based CPT codes for online evaluation and treatment (E-Visit)
- A communication between a patient and their provider through an online patient portal
- Especially of clinical utility during the pandemic for physician/or other qualified health care professionals

Online Digital Evaluation and Management (99421-99423; 98970-98972)



- 3 CPT time-based evaluation and management codes for online/digital services
- To be used for providing online E/M services to established patients who have not been seen in the past 7 days for an E/M visit and will not be seen in the next 7 days for an in-person visit
- **Physician/Advanced Practitioner Services (Established Patient)**
 - 99421 5-10 minutes
 - 99422 11-20 minutes
 - 99423 21 or more minutes
- **Qualified non-physician health care professionals (Established Patient)**
 - 98970 5-10 minutes
 - 98971 11-20 minutes
 - 98972 21 or more minutes

Online Digital Evaluation and Management



- Includes review, assessment, interaction with other clinical staff, management plan, and communication with patient (in HIPAA-compliant platform)
- Services must be initiated by the patient using a digital platform
- Time of the work can be cumulative over a 7-day period
- Bill once for cumulative time during a 7-day period
- Time includes work of all providers in the same group
- Time includes review of patient's initial inquiry, any interaction with the clinical staff focused on the problem and development of management plans, including generation of prescriptions and ordering of tests; and subsequent non-face-to-face communication with the patient
- Cannot bill if separately reportable E/M occurs within 7 days after completing digital E/M
- Cannot bill if separately reportable E/M for the same/related problem occurs within 7 days before digital E/M
- Do not bill if digital E/M is within the post-op period of a procedure
- Patients may be required to pay the same copay as for other medical services
- It is unclear at this time whether the established patient rule, or the requirement that the patient initiate these services is waived during the COVID-19 Public Health Emergency depending on payer

Online Digital Evaluation and Management



- Documentation

- Clearly identify services as non-face-to-face online/digital E/M
- Location of the provider and the patient should be documented
- Document all activities for the 7-day reporting period
- Time must be documented
- For physician/QHP services, do not include other staff time
- Document discussion with patient
- Verify and document patient understanding of plan and instructions
- Document any referrals and orders
- All entries related to the service must be signed and dated

Telephone (Audio-Only) Services (99441-99443; 98966-98968)



- Telephone E/M services may be provided to a patient, parent, or guardian (established patient)
- Do not originate from a related E/M service within the previous 7 days and do not lead to an E/M service or procedure within the next 24 hours or soonest available appointment
- Some payers added these to the list of telehealth services that may be reimbursed



Telephone (Audio-Only) Services (99441-99443; 98966-98968)



- The following codes may be used
- Physicians/Advanced Practitioner Services
 - 99441 5-10 minutes
 - 99442 11-20 minutes
 - 99443 21-30 minutes
- Non-physician services
 - 98966 5-10 minutes
 - 98967 11-20 minutes
 - 98968 21-30 minutes



Telephone (Audio-Only) Services (99441-99443; 98966-98968)



- Beginning March 1, 2020, and for the duration of the COVID-19 public health emergency, CMS will cover telephone evaluation and management (E/M) services (CPT codes 99441-99443)
- Many private payers are also covering telephone E/M services as telehealth services delivered using audio-only (check with your payer)



Telephone (Audio-Only) Services (99441-99443; 98966-98968)



- Services must be initiated by the patient
- Used for established patient only (may be waived during pandemic; check with payer)
- Must not originate from E/M performed within the previous 7 days
- Cannot bill if telephone service leads to an E/M or procedure within the next 24 hours or earliest available appointment
- 99441-99443 are for physician and APN services. 98966-98968 are used for non-physician clinical staff.



Telephone (Audio-Only) Services (99441-99443; 98966-98968)



- Documentation
 - Document date and time and content of phone discussion
 - Total time of the phone call must be documented
 - Location of the provider and the patient should be documented
 - Include instructions given and patient understanding of instructions
 - Document all follow-up calls with patient or other providers
 - Include tests ordered and any referrals made
 - If other physicians/clinical staff are involved in decision-making, document their input
 - Sign and date medical record entries



Example

- Olive is a 29yo G3P2, 34 weeks pregnant, with GDMA1, quarantined at home during the COVID-19 pandemic. She was seen in the MFM office last week for evaluation and ultrasound and was doing well. All ultrasounds have been normal to date. She saw her OB earlier this week. She lives in a rural area. Since seeing MFM last week, she has had several elevated blood sugars and wants to discuss what she should do. Her OB is requesting a consultation with MFM Dr. Stevenson.
- Dr. Stevenson only has telephone services (audio only) Dr. Stevenson calls Olive and reviews her blood sugars over the phone. He discusses option for treatment including oral hypoglycemics or insulin management if blood glucose control does not improve. He documents the content of the counseling and notes that total time was 10 minutes.

Recommended coding: 99441 (reimbursement payer specific)



Care Coordination and Interprofessional Consultations



- MFM subspecialists frequently need to speak with other physicians for patient care coordination and/or are asked by other physicians to provide assistance, opinion and consultation to assist in the diagnosis, management, and treatment of patients separate from the patient face-to-face visit

Care Coordination and Interprofessional Consultations



- MFM consulting subspecialists may bill when there is a need to speak with and coordinate care for their patient and/or when another physician requests an opinion and/or treatment advice
- The codes are all time-based codes and provided by phone, internet or electronic health record

Coordinating care for patients as part of an outpatient office visit



- If a patient is seen for an outpatient MFM office visit and discussion with another specialist, such as pediatric cardiologist or genetic counselor, is required, then “discussion of management or test interpretation with external physician or other QHP” counts as a Data Category 3 Moderate point when billing in the outpatient office using Medical Decision Making (MDM) to identify your E/M Level of Service (LOS).

Coordinating care for patients as part of an outpatient office visit



- For example, if you saw a patient in the office for fetal anomalies counseling and discussion, then contacted the pediatric cardiologist to discuss your findings and set up a fetal echocardiogram and spoke with your genetic counselor to set up your plans for further testing, then this would be rolled into your E/M LOS for that office visit.
 - If you are billing based on Total Time according to the 2021 E/M Coding Guidelines, the time spent in this care coordination would count towards your E/M LOS.
- If there is no related patient encounter in your office and instead you are providing consultation to another physician, then interprofessional codes, described below, would be a more appropriate choice.



Interprofessional Codes (99446-99451)



- Interprofessional codes should be utilized by MFMs who communicate with referring OBGYN (or other treating physicians) regarding a diagnosis or management of a patient
- These codes are defined as an E/M service in which a patient's treating provider (OBGYN attending) requests the opinion and/or treatment advice of a consultant (MFM attending) with specific specialty expertise to assist the OBGYN in the diagnosis or management of a patient's problem.



Interprofessional Codes (99446-99451)



- These services are utilized to help bill/code appropriately for team-based approaches to care, and do NOT include physician time with the patient.
- There is no face-to-face encounter on the part of the MFM (consultant).
- Requires both a verbal and written follow-up report



Interprofessional CPT Code Descriptions

- 99446: 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 healthcare professional; 5-10 minutes of medical consultative discussion and review
- 99447: ...11-20 minutes
- 99448: ...21-30 minutes
- 99449: ...31 minutes or more
- 99451: 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 healthcare professional, 5 minutes or more of medical consultative time. (*Does not include any verbal interaction between practitioners. It is just a written report.)



Caveats



- Can be used for new or established patients
- Can be reported for a new/acute or exacerbated/chronic problem
- Only reported by the consultant (MFM) when requested by another provider
- Can only be reported once in 7 days for the same patient
- Are reported based on cumulative time for those 7 days (even if you consult every day)
- Can NOT be used if a transfer of care or face-to-face consult occurs within next 14 days
- Can NOT be used if you (MFM) saw the patient for face-to-face time in the last 14 days
- Majority of time must be medical consultative verbal or internet discussion (greater than 50%), and appropriately documented. If greater than 50% is in data review and/or analysis, do not bill these codes.
- 99451 may be billed if more than 50% of the 5-minute time is data review and/or analysis
- Written or verbal request should be documented in the patient's medical record, including the reason for the consult
- Require both a verbal and written follow-up report



MFM Requesting, 99452



- Also, potentially of relevance to MFM, is if a different subspecialty consult/referral is required (eg, neurology, pulmonology, cardiology), and the MFM is the primary/requesting physician, code 99452 can be used.
 - 99452: interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified healthcare professional, 30 minutes
- Code 99452 describes the services that the treating physician (if MFM is primary/requesting physician) would spend in preparation for communication with a consulting physician. The treating physician must prepare for the interaction, so he or she uses the consultant's time wisely.



99452 Caveats



- Reported by physician requesting the non face-to-face consult/opinion
- Reported only when patient is NOT on site with the physician at the time of the request
- Can NOT be reported more than once in 14 days and per patient
- Includes time preparing for the referral/discussion with the consultant
- Requires minimum of 16 minutes of time
- Can be reported with prolonged services (99358, 99359)

It is important for physicians to get the patient's permission for these types of interprofessional consults so that the patient is aware/consents and because they will be billed and may require a co-pay/cost sharing. Documentation of the patient/family's verbal consent in the medical record is required for each interprofessional consultation service.



Example 1

- On Friday afternoon, you Dr. MFM, are contacted by one of your referring OBGYN groups regarding a patient they saw this week, complaining of itching on her palms/soles. The bile acids and LFTS are noted in your hospital system's EMR. Dr. OBGYN wants your opinion about antenatal testing and timing of delivery. The patient is otherwise a 25-year-old G1, who is otherwise healthy at 32 weeks gestation. You have seen her earlier this pregnancy for her anatomy ultrasound. Her pregnancy is managed by Dr. OBGYN. You spend 5 minutes reviewing these lab results, and looking through the patient's last progress note to ensure vitals were normal and no other issues are of concern. You contact Dr. OBGYN by phone and spent about 11 minutes discussing the plan of care. You spend an additional 4 minutes typing up a note that you will fax to their office with your recommendations.
- *How is this reported? 99447*
- Total time spent is 20 minutes (5 minutes reviewing chart/prep, 11 minutes discussing the case and plan of care, 4 minutes typing up your note), more than 50% was consultative discussion, included provider verbal interaction.



Example 2



- You Dr. MFM sees a patient in clinic with multiple medical problems. You see and evaluate the patient and order tests. While following up your test results, you identify a problem that you would like to discuss with Cardiology. You send a message to the cardiologist requesting a non face-to-face consult to discuss the patient. You prepare and send an e-message via your EHR InBasket to the cardiologist summarizing patient history and clarifying questions. Cardiologist reviews data and either replies by e-message or phone call stating the patient needs x, y, and z, but does not need a face-to-face cardiology consult. You Dr. MFM then summarize the discussion in documentation encounter. Total time spent 35 minutes.
- *How is this reported? 99452*



Some Notes



- Diagnosis Coding
 - Must still link your correct ICD-10 Codes to the procedure/service
- Patient Cost-Sharing
 - CMS stated physicians have option of waiving/reducing the patient cost-sharing requirement but would NOT increase reimbursement rates for the physician to cover that cost
- Payer resources
 - Check each payer's policies on their website as updated frequently
 - Check State website for updates for CMS



Thank you. Questions