Department of Health and Human Services

Centers for Medicare & Medicaid Services

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Interprofessional Internet Consultation (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449)

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3. Interprofessional Internet Consultation (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449)

As part of our standard rulemaking process, we received recommendations from the RUC to assist in establishing values for six CPT codes that describe interprofessional consultations. In 2013, CMS received recommendations from the RUC for CPT codes 99446 (Interprofessional telephone/Internet 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; 5-10 minutes of medical consultative discussion and review), 99447 (Interprofessional telephone/Internet 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; 11-20 minutes of medical consultative discussion and review), 99448 (Interprofessional telephone/Internet 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; 21-30 minutes of medical consultative discussion and review), and 99449 (Interprofessional telephone/Internet 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; 31 minutes or more of medical consultative discussion and review). CMS declined to adopt these codes for separate payment, stating in the CY 2014 PFS final rule with comment period that these kinds of services are considered bundled (78 FR 74343). For CY 2019, the

CPT Editorial Panel created two new codes to describe additional consultative services, including a code describing the work of the treating physician when initiating a consult, and the RUC recommended valuation for new codes, CPT codes 99452 (Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes) and 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 health care professional, 5 or more minutes of medical consultative time). The RUC also reaffirmed their prior recommendations for the existing CPT codes. The six codes describe assessment and management services conducted through telephone, internet, or electronic health record consultations furnished when a patient's treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a consulting physician or qualified healthcare professional with specific specialty expertise to assist with the diagnosis and/or management of the patient's problem without the need for the patient's face-to-face contact with the consulting physician or qualified healthcare professional. Currently, the resource costs associated with seeking or providing such a consultation are considered bundled, which in practical terms means that specialist input is often sought through scheduling a separate visit for the patient when a phone or internet-based interaction between the treating practitioner and the consulting practitioner would have been sufficient. We believe that proposing payment for these interprofessional consultations performed via communications technology such as telephone or Internet is consistent with our ongoing efforts to recognize and reflect medical practice trends in primary care and patient-centered care management within the PFS.

Beginning in the CY 2012 PFS proposed rule (76 FR 42793), we have recognized the changing focus in medical practice toward managing patients' chronic conditions, many of which particularly challenge the Medicare population, including heart disease, diabetes, respiratory disease, breast cancer, allergies, Alzheimer's disease, and factors associated with obesity. We have expressed concerns that the current E/M coding does not adequately reflect the changes that have occurred in medical practice, and the activities and resource costs associated with the treatment of these complex patients in the primary care setting. In the years since 2012, we have acknowledged the shift in medical practice away from an episodic treatment-based approach to one that involves comprehensive patient-centered care management, and have taken steps through rulemaking to better reflect that approach in payment under the PFS. In CY 2013, we established new codes to pay separately for transitional care management (TCM) services. Next, we finalized new coding and separate payment beginning in CY 2015 for chronic care management (CCM) services provided by clinical staff (81 FR 80226). In the CY 2017 PFS final rule, we established separate payment for complex CCM services, an add-on code to the visit during which CCM is initiated to reflect the work of the billing practitioner in assessing the beneficiary and establishing the CCM care plan, and established separate payment for Behavioral Health Integration (BHI) services (81 FR 80226 through 80227).

As part of this shift in medical practice, and with the proliferation of team-based approaches to care that are often facilitated by electronic medical record technology, we believe that making separate payment for interprofessional consultations undertaken for the benefit of treating a patient will contribute to payment accuracy for primary care and care management services. We proposed separate payment for these services, discussed in section II.H. of this final rule, Valuation of Specific Codes.

Although we proposed to make separate payment for these services because we believe they describe resource costs directly associated with seeking a consultation for the benefit of the beneficiary, we do have concerns about how these services can be distinguished from activities undertaken for the benefit of the practitioner, such as information shared as a professional courtesy or as continuing education. We do not believe that those examples will constitute a service directly attributable to a single Medicare beneficiary, and therefore neither the Medicare program nor the beneficiary should be responsible for those costs. We therefore solicited comment on our assumption that these are separately identifiable services, and the extent to which they can be distinguished from similar services that are nonetheless primarily for the benefit of the practitioner. We noted that there are program integrity concerns around making separate payment for these interprofessional consultation services, including around CMS's or its contractors' ability to evaluate whether an interprofessional consultation is reasonable and necessary under the particular circumstances. As the beneficiary would be liable for any cost sharing associated with these services, we also sought comment on the necessity of requiring patient consent for these, and whether than consent should be written or verbal. We solicited comment on how best to minimize potential program integrity issues, and noted we were particularly interested in information on whether these types of services are paid separately by private payers and if so, what controls or limitations private payers have put in place to ensure these services are billed appropriately.

The following is a summary of the comments we received regarding how best to minimize potential program integrity issues.

Comment: Almost all commenters were very supportive of CMS proposing separate payment for these services. Commenters pointed out that these are discrete physician services

undertaken for the benefit of the patient, and easily distinguished from consultations undertaken for the edification of the practitioner. One commenter stated as medical care moves toward more comprehensive patient-centered care management, frequent consultation with multiple specialists is necessary. Under the current model this means separate visits for the patients that are costly and inconvenient. Internet-based consultations between the treating practitioner and the consulting specialists provide appropriate, convenient and cost effective alternatives. Commenters were clear that, by not making separate payment for these services, CMS would not be accurately paying for the work of both the treating and consulting physicians in a consultative scenario.

Many commenters provided helpful responses to CMS' request for information on how to minimize program integrity concerns for these services. A few commenters provided suggestions as to how CMS could verify the medical necessity of the consultation, including verifying that the treating and consulting physician were of different medical specialties, requiring patient identifiers and documentation of how the interaction improved patient care, defining a time period under which an E/M visit and an Interprofessional Consultation cannot both be billed for the same diagnosis, and creating frequency limitations on billing. Others suggested that the treating physician must document that they acted on the recommendation of the consulting physician prior to billing for CPT code 99452. Commenters had a number of suggestions for items that CMS should require, including that Interprofessional Consultations should consist of focused questions that are answerable solely from information in the EMR; that they be answered in 3 business days; and that the consulting physician should restate the question in their response, provide recommendations for evaluation, management, and/or ongoing monitoring, provide a rationale for recommendations, and provide recommendations for

contingencies. Other commenters suggested that CMS could make separate payment contingent upon whether the underlying condition was urgent or related to critical care and that the consultation helped avoid transfer or interruption of care or that internal expertise was sought and was not available. Many commenters also encouraged CMS to avoid imposing overly restrictive documentation requirements. One commenter stated that, due to potential program integrity concerns, these services should be subject to the Medicare telehealth restrictions on beneficiary location and site of service. Another commenter recommended that CMS delay implementation until the program integrity concerns have been addressed. Other commenters encouraged CMS to monitor utilization for abuse.

Response: We thank commenters for their support and additional information on the ways in which these services are distinct physician services. We note that because these services are inherently non face-to-face (the patient need not be present in order for the service to be furnished in its entirety), they would not be considered as potential Medicare telehealth services under section 1834(m) of the Act. We appreciate the wealth of information and suggestions from commenters; however, we also agree with the many commenters who pointed out that adding many additional billing requirements may inhibit uptake for these services. As we note below, we are requiring documentation of verbal patient consent to receive these services, and are adopting existing CPT prefatory language. We plan to monitor utilization of these services and will consider making refinements to billing rules, documentation requirements or claims edits, including those suggested by commenters, through future rulemaking as necessary.

Comment: Many commenters suggested that CMS limit or eliminate beneficiary cost sharing for these services to obviate the question of patient consent entirely.

Response: Under current statute, we do not have the authority to change the requirements for the beneficiary cost sharing for these services.

Additionally, since these codes describe services that are furnished without the beneficiary being present, we proposed to require the treating practitioner to obtain verbal beneficiary consent in advance of these services, which would be documented by the treating practitioner in the patient's medical record, similar to the conditions of payment associated with separately billable care management services under the PFS. Obtaining advance beneficiary consent includes ensuring that the patient is aware of applicable cost sharing.

The following is a summary of the comments we received regarding whether to require the treating practitioner to obtain verbal beneficiary consent in advance of these services, which would be documented by the treating practitioner in the medical record similar to the conditions of payment associated with the care management services under the PFS, as well as comments on other aspects of this proposal.

Comment: Many commenters stated that verbal patient consent was an appropriate safeguard against unnecessary utilization, while others disagreed, stating that the requirement to obtain consent may cause unnecessary burden in cases where the patient is unresponsive or the need for the interprofessional consultation is urgent such as in a critical care or emergency setting. Other commenters stated that a single blanket patient consent to receive interprofessional consultation services would be preferable to minimize the need to obtain consent for each of what may be multiple consultations. One commenter questioned whether the consulting physician would need to verify that the beneficiary had consented, given that only the treating physician is in contact with the beneficiary.

Response: We understand the potential burden regarding obtaining consent. However, we believe that it is important for beneficiaries to consent to the service and thus be notified of their cost-sharing obligations. We note that under our current policy for several care management services, consent is required to be documented in the medical record. That policy was implemented, in part, based on feedback we received from practitioners reporting the care management services, to alleviate burdens of alternative approaches. Consequently, we believe the same requirement could be applied here, without imposition of significant burden.

We are finalizing that the patient's verbal consent is required, and that consent must be noted in the medical record for each service, consistent with the policy we are finalizing for the brief communication technology-based services (HCPCS code G2012) as noted above, as well as with the patient consent policies in place for care management services, under the PFS.

Comment: Commenters requested that CMS clarify whether billing for these services is limited to physicians or if other healthcare practitioners, such as nurses or physical therapists, may bill for these services as well.

Response: We appreciate commenters' request for clarification. We believe that billing of these services should be limited to those practitioners that can independently bill Medicare for E/M visits, as interprofessional consultations are primarily for the ongoing evaluation and management of the patient, including collaborative medical decision making among practitioners. We are therefore not finalizing any expansion of these services beyond their current scope.

Comment: A few commenters requested that CMS adopt CPT prefatory language for these services as is CMS' longstanding practice when adopting most new CPT coding.

Response: We agree with the commenters and confirm that we will be adopting existing CPT prefatory language regarding these services.

In summary, we are finalizing separate payment for CPT codes 99451, 99452, 99446, 99447, 99448, and 99449 describing Interprofessional consultations. We are finalizing a policy to require the patient's verbal consent that is noted in the medical record for each interprofessional consultation service. We note that cost sharing will apply for these services. These interprofessional services may be billed only by practitioners that can bill Medicare independently for E/M services.

For further discussion related to the valuation of these services, please see section II.H. of this final rule, Valuation of Specific Codes.