

PAYMENT FOR NON-FACE-TO-FACE SERVICES:

A Guide for the Psychiatric Consultant

Interprofessional Telephone/Internet/Electronic Health Record Consultations*

CPT Codes: 99446, 99447, 99448, 99449, 99451

* These codes should not be billed if your time spent consulting is part of a CoCM program and billed by the treating physician using the CoCM codes (99492-99494)

“Consult with Discussion” and “Consult without Discussion”

Medicare now pays for non-face-to-face limited consultation services where physicians and other qualified healthcare professionals are consulting about a patient without the patient present. These services include evaluation and management recommendations on patient care through the use of a secure platform (i.e., telephone, fax, or electronic health record (EHR)). This document is intended to help consulting psychiatrists understand how they might use the new codes in the care of patients who are being treated by other physicians and are NOT seen or evaluated by the consulting psychiatrist.

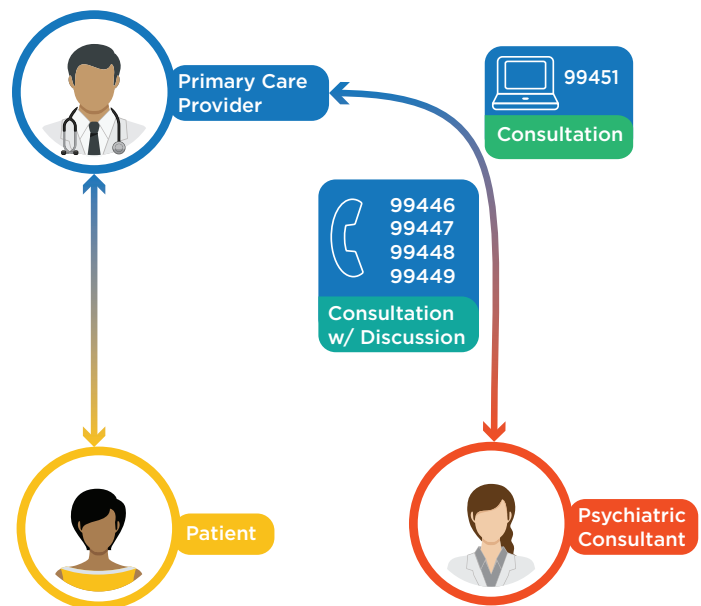
99446-99449 “Consult with Discussion” and 99451 “Consult without Discussion”

The patient’s primary care provider (PCP) requests the opinion/treatment advice of a psychiatrist or psychiatric consultant and includes the following:

- Case review provided via telephone/EHR/fax/internet
- Assessment and management recommendations by a psychiatric consultant
- A brief report is provided to the treating/requesting PCP

There are two situations where these codes **cannot** be used:

1. If an in-person visit with the psychiatric consultant has occurred within the previous 14 days or will occur within the next 14 days.
2. If the sole purpose of the contact is to transfer care or arrange for an in-person consultation with the psychiatric consultant.



Differences between the two code sets:

99446-99449 “Consult with Discussion”

(Time guidelines listed on page 2)

- More than 50% of the time must be devoted to the consultative discussion with the requesting primary care provider either verbally or online.
- Requires both a verbal and written report to the treating/requesting PCP
- Does not include any time spent communicating with the patient and/or family

99451 “Consult without Discussion” (5 minutes or more)

- Health record assessment via EHR/Internet/Fax and time to create a report is included in billable time
- Only a written report to the treating/requesting PCP is required
- Do not bill 99451 for services that last less than 5 minutes

Billing for the treating/requesting PCP

99452 is to be used by the PCP requesting the consult if 16-30 min of time is used preparing the referral and/or communicating with the psychiatric consultant. Cannot be reported more than once in a 14-day period per patient.

Additional codes are available for time exceeding 30 minutes:

- If patient is onsite: appropriate E/M plus prolonged service codes 99354, 99355, 99356, 99357
- Patient not present: non-face-to face prolonged service codes 99358, 99359

Both code sets:

Both sets of codes can be used for a patient new to the psychiatric consultant or for an established patient with a new problem or problem exacerbation.

Other stipulations:

- If more than one contact is needed to complete the e-consult—report one code with cumulative time over a 7-day period

Coverage for these services and payment rates will vary.

Case Examples

Example 1:

This communication was sent via a secure electronic platform to a contracted psychiatric consultant from a primary care clinician.

Reason for consult:

“I wonder if it might not be beneficial to see if this patient can get by on fewer psychoactive medications.”

Current Presentation:

64-year old man had first psychotic break and hospitalization 4 years ago and given first diagnosis of bipolar affective disorder. Has also had left arm dystonia since being a teenager and has been on psychoactive medication for that. Has not seen a psychiatrist in 3+ years, all psych meds filled in primary care. Overall, no current hallucinations, feels depression mostly

- These codes cannot be used with prolonged service codes 99358-9

Recommendations:

- Include the written or verbal request and specify the reason for the referral in the report and the patient’s medical record.
 - Document as appropriate, including date and time spent.
 - Retain the record of request.
- Requesting PCP should inform the patient they are asking the advice of a psychiatric consultant and that there may be an associated co-pay/coinsurance for this service.

Time guidelines and approximate reimbursement under 2020 Medicare Physician Fee Schedule:

“Consult with Discussion”

(medical consultative discussion and written report):

- **99446:** 5-10 minutes \$18
- **99447:** 11-20 minutes \$37
- **99448:** 21-30 minutes \$56
- **99449:** 31+ minutes \$74

“Consult without Discussion”

(health record review and written report, no verbal discussion required):

- **99451:** 5 or more minutes \$38

controlled. His co-pay to see a psychiatrist is \$45, which is prohibitive, so I’m doing this consult to save him money and because he is presently psychiatrically stable.

Medications:

Aripiprazole 2.5 mg/day; citalopram 20 mg/day; desipramine 25 mg/day; clonazepam 1 mg QID for dystonia; trihexyphenidyl 5 mg five times a day for dystonia. Also, losartan, tamsulosin

My Thoughts/Plans:

- Consider lowering aripiprazole to 1 mg/day; then consider weaning or d/c desipramine
- Neurology managing clonazepam and trihexyphenidyl related to dystonia and I was not going to consider reducing these

Time: 14 minutes total time
(chart review and documentation)

Billing: 99451

(all communication was electronic, greater than 5 minutes)

This section is sent back to the PCP and put into the patient's EHR

Psychiatric Consultant Response:

Thank you for your request. I would be inclined not to change his medications much. He has been stable not that long, relatively speaking and if he doesn't have side effects and is not asking to be taken off meds, I would give him another year or two on this regimen. If you do decide to decrease his psychotropic medications, I would start with one of the antidepressants, not aripiprazole. Aripiprazole is already at a very low dose and is working as a mood stabilizer (in addition to antipsychotic effect), protecting him from going into depression or mania. Desipramine is stronger and more effective for depression of his two antidepressants, but also has more side effects and more likely to cause switch to manic episode. So it's hard to decide which antidepressant is safer to taper off. I would lean toward desipramine, probably because of potential cardiac side effects. It is recommended to check ECG for QTc

prolongation on anyone over age 50 who is on desipramine. If you still feel that you would like to decrease aripiprazole, I would decrease it to 2 mg a day and see how he does. Hope this helps.

The above treatment considerations and suggestions are based on a review of a specific clinical question from the patient's primary care provider. I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and current clinical status. Please feel free to contact me with any questions about the care of this patient.

Dr. Johns, Psychiatric Consultant
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Example 2:

Reason for Consult:

I noticed that despite being diagnosed with bipolar disorder, patient's medications appear to be an antidepressant and a sleep med. I feel that I learned that antidepressants for someone with bipolar disorder can be risky in that it may potentially trigger manic episodes. Is this a risk to be concerned about? (I'd like to call you over my lunch break today to discuss.)

Primary care provider and psychiatric consultant then have a phone conversation summarized as the following:

Primary Care Provider:

Current Presentation:

45-year-old male currently reporting depressive symptoms and likely experiencing a depressive episode (bipolar disorder diagnosis). Patient has been diagnosed with bipolar disorder for many years and has had manic, mixed, and depressed episodes in the past. Patient recently had a family member pass away and depression has come on strongly over the last two weeks.

Medications:

Patient has had poor medication compliance. Medications include psych meds (Fluoxetine 20 mg 1x/day and trazadone 100 mg at bed for sleep) and other non-psychotropic or non-psychiatric meds.

My Thoughts/Plans:

We have been discussing the importance of adherence to medication, and particularly so now that patient is experiencing increased symptoms after the death of a family member. Therapy will be continued and grief work will likely be a part of it, however some med questions caught my eye. I saw he was not on a "bipolar med." I want to treat the depression, but I don't want to induce a mania.

Psychiatric Consultant Response:

You are correct about antidepressants having potential the risk of inducing a manic episode. But each case needs to be reviewed individually and risks vs. benefits should be carefully examined. The depression in Bipolar Disorder could be very severe and overall carries a higher risk of suicide. Whoever is prescribing his meds, should look

into the trajectory and the severity of his episodes and symptoms. One should look and answer the following questions: how long does average episode last; how much or percentage of time patient was in 'neutral' state; did he need hospitalization when manic; has he ever been suicidal when depressed; and so on. Having said all this—yes, I would be somewhat concerned that this patient is not on a mood stabilizer. Mood stabilizers have a protective effect from a switch to both depression and mania.

Further Conversation:

Primary care provider added that he did recall patient had a hospitalization 10 years previous but didn't know the details. He was pretty certain that the diagnosis of bipolar was correct and at times the ups had caused

family problems. The psychiatric consultant then recommended adding the medication quetiapine to treat both the depression and prevent future manic episodes. Recommended holding trazadone for now as quetiapine will help with any insomnia.

Time: 7 minutes total time (10 minutes of time speaking to Dr. X by phone about the case and giving recommendations and 7 additional minutes of chart review and documentation)

Billing: 99447—Medical Consultative Discussion and review, 11-20 min
17 min of time (10 min of time speaking to Dr. X about the case and giving recommendations)

This section is sent back to the PCP and put into the patient's EHR

Documentation to chart:

Reason for consult:

As reported by Dr. Bell: "I noticed that despite being diagnosed with Bipolar, patient's meds appear to be an anti-depressant and an anti-anxiety medication as well as some sleep meds. I feel that I learned that anti-depressants for someone with bipolar disorder can be risky in that it may potentially triggering manic episodes. Is this a risk to be concerned about?"

Spoke with Dr. Bell about his concern for patient JD.
Psych meds: fluoxetine 20mg and trazadone 100mg

Assessment:

Bipolar-depressed

Plan:

- Continue fluoxetine 20mg/day
- Start quetiapine 50mg QHS and increase to 100mg at day 5. Re-evaluate and quetiapine can continue

to be titrated up in 50mg doses to an average dose of 200-300mg QHS.

- Monitor for increased weight gain and metabolic syndrome
- Stop trazadone as many patients find quetiapine sedating.

The above treatment considerations and suggestions are based on a consultative discussion with the patient's primary care provider. I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and current clinical status. Please feel free to contact me with any questions about the care of this patient.

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