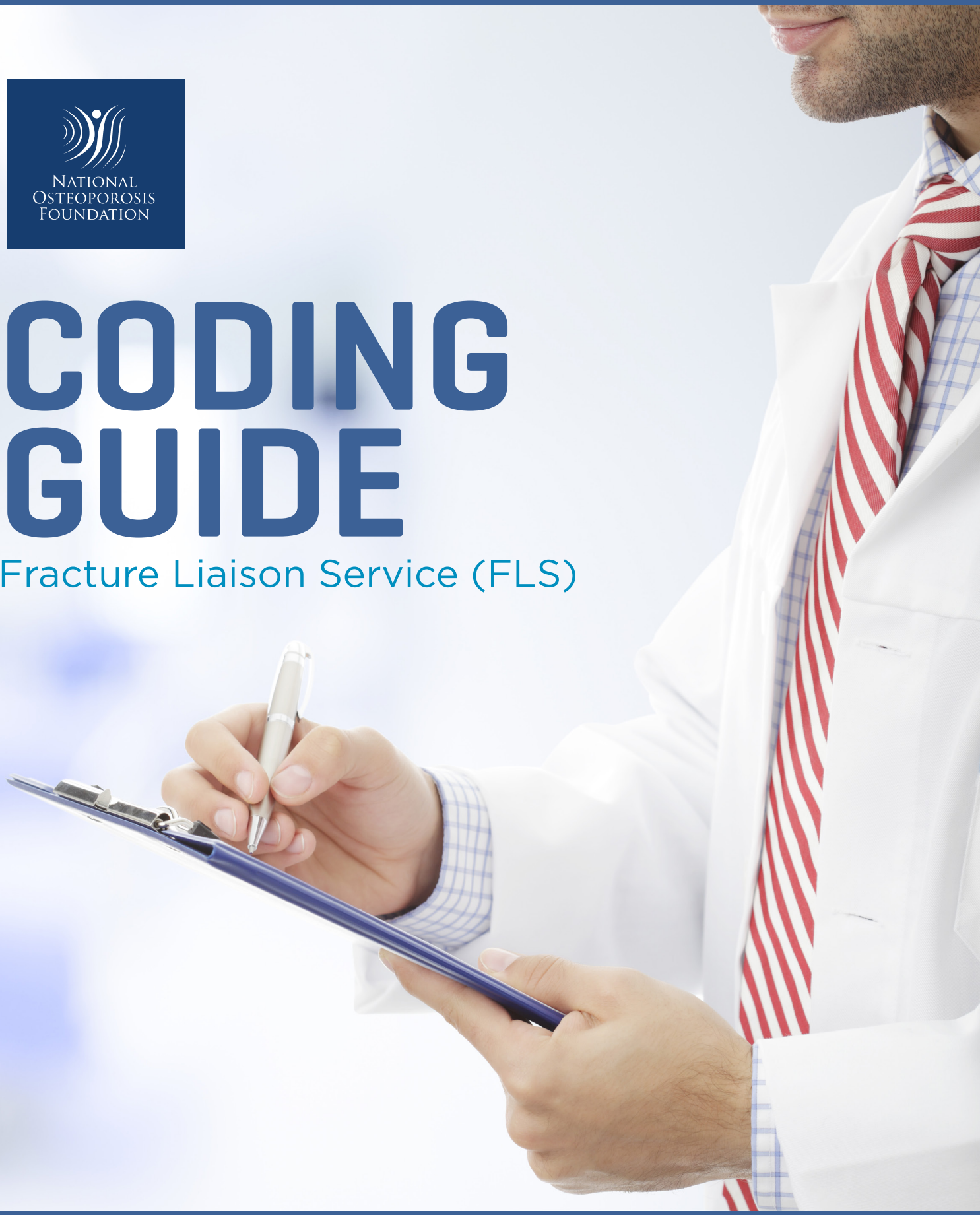
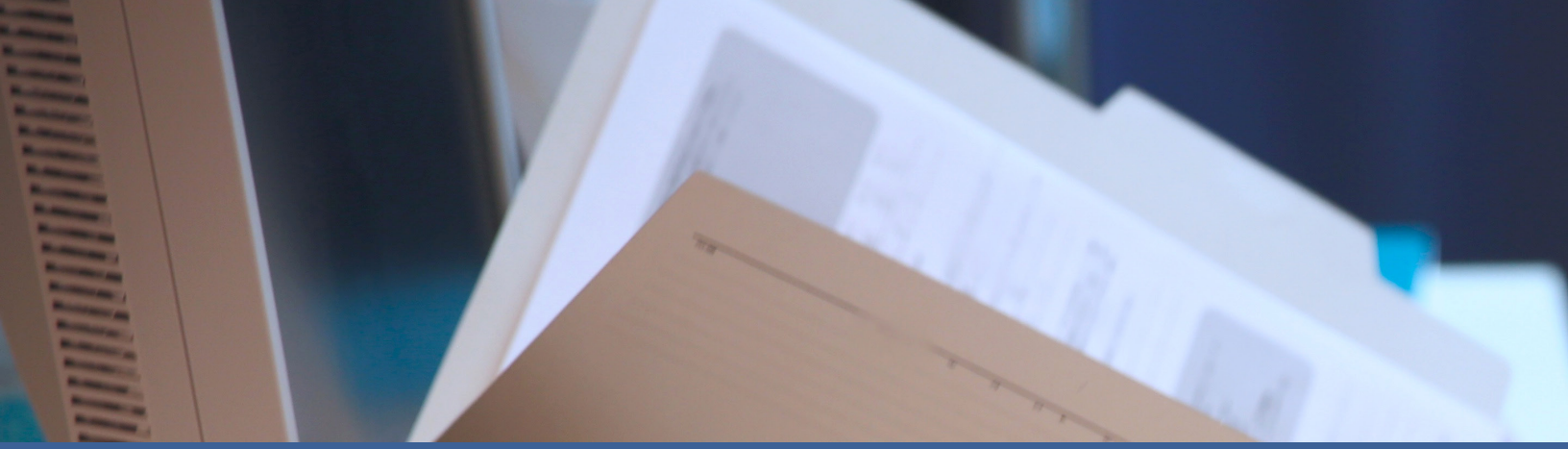
National Osteoporosis Foundation

CODING GUIDE

Fracture Liaison Service (FLS)





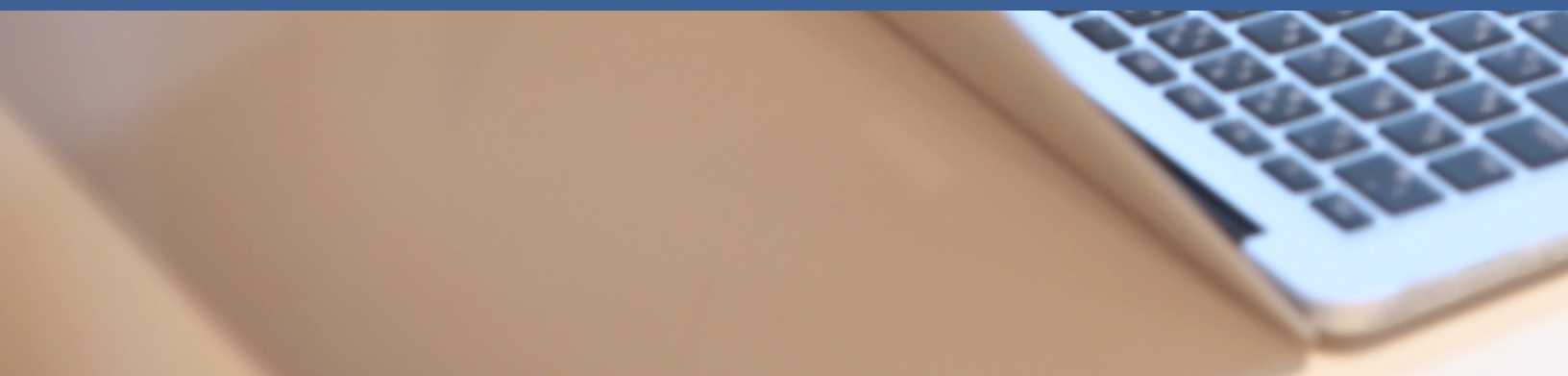
FLS CODING GUIDE

This Fracture Liaison Service (FLS) Coding Guide provides details on currently available quality and value-based codes to help offset costs for FLS implementation in various settings. This is a general guide offering a broad overview to help get you started. Please refer to your individual institution for more details. Proper coding is vitally important as reimbursement for services can vary on the state and/or specialty as the type of provider who bills for and performs the service. In order to ensure that you are being fully reimbursed and remain in compliance with payer requirements, we recommend that you discuss the codes that are the best fit for your FLS with your FLS billing specialist.

For a brief introduction, current procedural terminology (CPT) is a medical code set that is used to report medical, surgical, and diagnostic procedures and services. The codes are used in conjunction with ICD-10-CM numerical diagnostic coding during the electronic medical billing, claims submission, and payment process. CPT codes are developed and updated by the American Medical Association (AMA).

ICD-10-CM diagnosis codes (formerly known as ICD-9) are recognized by the Centers for Medicare and Medicaid Services' (CMS) International Classification of Disease (ICD)-10 code as diagnosis codes. The ICD-10 code sets are meant to provide more specific information and help to standardize care and help with cost savings. A CPT code must have an associated ICD-10 code that sufficiently describes the patient for proper billing and to show medical necessity in order to avoid delays and or denials in reimbursement.

Specific to the Fracture Liaison Service, in the outpatient setting, the CPT codes primarily will be office visit codes known as E/M (evaluation and management codes) and the ICD-10 code sets utilized for FLS will include common medical diagnoses associated with patients who have osteoporosis and/or compromised bone quality and are at risk for future fractures.



Depending on the setting of your FLS program you may find that the CPT codes describing your services vary from those presented in this guide. The ICD-10 codes, however, will be the same medical diagnosis codes regardless of where the patient is identified, and the osteoporosis addressed. For example, if the FLS patient is seen by a provider in orthopedics, that provider would use the medical code for the bone fragility diagnosis, not the "fracture code."

If the patient is seen within the global period (90-day post fracture intervention) and is seen in the orthopedic specialty, Modifier 24 should be used to ensure appropriate reimbursement so that the billing does not get included or lost as part of the global care for the fracture. Remember - the fracture is the acute condition justifying a fracture care intervention and signaling the need to follow-up on the underlying, chronic bone fragility diagnosis. Since the FLS program interventions address that underlying bone fragility, the ICD-10 codes for the medical diagnosis are appropriate.

Medicare uses the Healthcare Common Procedure Coding System (HCPCS). The "Level I" HCPCS codes are the same as CPT codes from the American Medical Association. The Level II HCPCS codes are used to identify products, supplies and services not included in the CPT codes, such as ambulance services, DME and certain medications that are administered by a health care provider.

NOTE: This coding guide includes a discussion on choosing the appropriate E&M code as these are the most commonly reported services in a FLS. FLS programs should, however, discuss their coding practices with their FLS billing specialist to confirm compliance with coding guidelines and ensure that their documentation supports the level of service reported on claims.

FLS programs should also be aware that the guidelines for reporting and documenting use of specific E&M codes will change beginning in 2021. The information in this documentation applies only to services performed before January 1, 2021.

IDENTIFYING PATIENTS FOR FLS INTERVENTIONS

The first issue any FLS program addresses is identifying patients for secondary prevention of an osteoporotic fracture. In the inpatient setting, hospitals will assign a diagnosis related group (DRG) (in Medicare, this is a medical severity diagnosis related group (MS-DRG)) in order to receive reimbursement, and these DRG codes may provide the simplest mechanism for identifying patients receiving fracture care as inpatients. For other settings, such as the emergency room or outpatient center, the ICD-10 code reported with the procedure code would serve to identify appropriate patients for FLS follow-up and care.

NOTE: The codes listed below are provided to guide FLS program efforts to identify patients treated for a likely fragility fracture

MS-DRGs (Hospital Inpatient)

453	Combined anterior/posterior spinal fusion w MCC
454	Combined anterior/posterior spinal fusion w CC
455	Combined anterior/posterior spinal fusion w/o CC/MCC
456	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w MCC
457	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w CC
458	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w/o CC/MCC
459	Spinal fusion except cervical w MCC
460	Spinal fusion except cervical w/o MCC
469	Major Joint Replacement or Reattachment of Lower Extremity With MCC
470	Major Joint Replacement or Reattachment of Lower Extremity Without MCC
471	Cervical spinal fusion w MCC
472	Cervical spinal fusion w CC
473	Cervical spinal fusion w/o CC/MCC
480	Hip & femur procedures except major joint w MCC
481	Hip & femur procedures except major joint w CC
510	Shoulder, elbow or forearm proc,exc major joint proc w MCC
511	Shoulder, elbow or forearm proc,exc major joint proc w CC
512	Shoulder, elbow or forearm proc,exc major joint proc w/o CC/MCC
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC
515	Other musculoskeletal system & connective tissue O.R. procedures with MCC
516	Other musculoskeletal system & connective tissue O.R. procedures with CC
517	Other musculoskeletal system & connective tissue O.R. procedures without CC
518	Back and neck procedure exc spinal fusion with MCC
519	Back and neck proc exc spinal fusion with CC
520	Back and neck proc exc spinal fusion without CC/MCC
533	Fractures of femur with MCC
534	Fractures of femur without MCC
535	Fractures of hip and pelvis with mc
536	Fractures of hip and pelvis without mcc
542	Pathological fractures and musculoskeletal and connective tissue malignancy with MCC

543 Pathological fractures and musculoskeletal and connective tissue malignancy with CC
544 Pathological fractures and musculoskeletal and connective tissue malignancy CC/MCC
562 FX, sprain, strain and dislocation except femur, hip, pelvis & thigh with MCC
563 FX, sprain, strain and dislocation except femur, hip, pelvis & thigh without MCC
906 Hand procedures for injuries

ICD-10 Codes Potentially Indicative of a Fracture Requiring FLS Follow-up (Outpatient)

S22.XX	Fractures of rib(s), sternum
S32.XX	Fractures of lumbar spine and pelvis
S42.XX	Fractures of shoulder and upper arm
S52.XX	Fracture of forearm
S62.XX	Fracture at wrist and hand level
S72.XX	Fracture of femur
S79.XX	Other injuries of hip and thigh
S82.XX	Fracture of lower leg
M80.XXX	Age-related osteoporosis with current pathological fracture
M84.30XA	Stress fracture, pathological fracture

ICD-10 DIAGNOSIS CODES FOR USE WITHIN A FLS PROGRAM

The ICD-10 codes below capture most medical conditions for which Medicare will provide reimbursement for a bone density test. There are many disorders along with many medications that are associated with osteoporosis that can be included for the need for a bone density test. These codes are likely appropriate for a first FLS encounter with a patient, particularly if the patient has not yet received an osteoporosis diagnosis. Once the clinician(s) has evaluated the patient and determined appropriate treatment course, the FLS program should code medical diagnosis with specificity.

ICD-10 Codes Confirming Medical Necessity for Bone Density Testing

E05	Hyperthyroidism
E21.0	Primary hyperparathyroidism
E21.3	Hyperparathyroidism, unspecified
E23.0	Hypopituitarism
E24.0	Pituitary-dependent Cushing's disease
E24.2	Drug-induced Cushing's syndrome
E24.3	Ectopic ACTH syndrome
E24.4	Alcohol-induced pseudo-Cushing's syndrome
E24.8	Other Cushing's syndrome
E24.9	Cushing's syndrome, unspecified
E28.310	Symptomatic premature menopause
E28.319	Asymptomatic premature menopause
E28.39	Other primary ovarian failure
K90.0	Celiac disease

E29.1	***Testicular hypofunction – CMS does not list this code as "covered"***
E34.2	Ectopic hormone secretion, not elsewhere classified
E89.40	Asymptomatic postprocedural ovarian failure
E89.41	Symptomatic postprocedural ovarian failure
E89.5	***Postprocedural testicular hypofunction – CMS does not list this code as "covered"***
E95.8	Other specified menopausal and perimenopausal disorders
E95.9	Unspecified menopausal and perimenopausal disorder
M81.0	Age-Related Osteoporosis without Current Pathological Fracture
M81.6	Localized osteoporosis
M81.8	Other osteoporosis without current pathological fracture
M85.9	Disorder of bone density and structure, unspecified
M89.9	Disorder of bone, unspecified
M94.9	Disorder of cartilage, unspecified
Q78.0	Osteogenesis imperfecta
Q96.0	Karyotype 45, X
Z13.820	Encounter for screening for osteoporosis (may be rejected by Medicare)
Z78.0	Asymptomatic menopausal state
Z79.3	Long term (current) use of hormonal contraceptives
Z79.51	Long term (current) use of inhaled steroids
Z79.52	Long term (current) use of systemic steroids
Z79.83	Long term (current) use of bisphosphonates
Z87.310	Personal history of (healed) osteoporosis fracture

CODING FOR FLS OFFICE VISITS

Evaluation and Management (E&M) services are likely the most frequently performed services within FLS programs. Selecting which E&M code to report for a particular patient encounter can be complicated by the fact that (1) CMS issued guidance in 1995 AND in 1997, and providers can choose which guidance to follow (but cannot shift from one to the other); and (2) for some encounters, it is appropriate to bill based on the amount of time spent with the patient rather than by "scoring" the various components of the visit. The key, however, is to DOCUMENT appropriately. Medicare claims payment contractors (MACs) tend to believe that if it isn't documented, it didn't happen. Frequent use of high-level E&M codes can trigger claims scrutiny.

The CPT coding set distinguishes between new patients and established patients.

New Patient: A patient who has not, within the previous 3 years, received any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice.

Established Patient: A patient who has received services from the physician/NPP or another physician of the same specialty within the same group practice within the previous 3 years.

NOTE: Clinicians should bill any laboratory or imaging studies in addition to the E&M code.

WHEN CAN TIME SPENT WITH PATIENT BE USED TO SELECT E&M CODE?

When counseling and/or coordination of care takes up more than 50% of the physician/patient encounter, it is appropriate to use time as the key factor in determining which level of E&M service to report on a claim. If a clinician is using time to determine the appropriate E&M code, it is imperative to document not only the entire amount of time spent with the patient, but also the "start" and "stop" times. Clinicians must also describe the counseling provided and/or activities performed to coordinate care

The table below describes the level of services for each of the E&M codes used for a new or established patient, as well as the expected duration of the visit.

E/M CODE	MEDICAL DECISION MAKING	HISTORY	EXAM	TIME SPENT FACE TO FACE (AVG.)
99201 (new)	Straight-forward	Problem focused	Problem focused	10 min.
99211 (established)	Straight-forward	Problem focused	Problem focused	5 min.
99202 (new)	Straight-forward	Expanded problem focused	Expanded problem focused	20 min.
99212 (established)	Straight-forward	Expanded problem focused	Expanded problem focused	10 min.
99203 (new)	Low complexity	Detailed	Detailed	30 min.
99213 (established)	Low complexity	Detailed	Detailed	15 min.
99204 (new)	Moderate complexity	Comprehensive	Comprehensive	45 min.
99214 (established)	Moderate complexity	Comprehensive	Comprehensive	25 min.
99205 (new)	High complexity	Comprehensive	Comprehensive	60 min.
99215 (established)	High complexity	Comprehensive	Comprehensive	40 min.

DETERMINING THE APPROPRIATE E&M CODE BASED ON THE NATURE AND COMPLEXITY OF THE SERVICE

Three key components guide the determination on the appropriate level of E&M services provided, each with its own documentation requirements: History, Exam and Medical decision making. FLS programs may find that the code that fits the nature and extent of services is insufficient given the time spent with the patient, i.e., counseling and care coordination comprised less than half the total time but was still significant. In those instances, it is appropriate to report the appropriate E&M code as well as an additional code for extended time with the patient. The E&M components, as well as the add-on codes are discussed below.

HISTORY

There are 4 types of history that could apply to an office visit – problem focused, expanded problem focused, detailed, and comprehensive. The type of history depends on the extent of information gathered, which should be based on clinical judgment and the nature of the presenting problem. There are 4 elements to the patient history component – chief complaint (CC), history of presenting illness (HPI), review of systems (ROS), and past, family, and/or social history (PFSH). The elements to perform and document each type of history increase in intensity as the type of history becomes more intensive.

The chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, or reason for the patient encounter. It is often stated in the patient's own words, but within FLS programs, the CC for an initial visit would likely be described within the context of secondary prevention of a fragility fracture.

The history of present illness (HPI) is a chronological description of the development of the patient's present illness. A brief HPI will contain one to three of the elements listed below, while an extended HPI would describe at least four elements or associated comorbidities or at least three chronic or inactive conditions.

- Location (example: left hip fracture)
- Quality
- Severity (example: future fracture risk, bone density)
- Duration
- Timing
- Context (example: fell from standing level)
- Modifying factors
- Associated signs and symptoms

The review of systems (ROS) is an inventory of body systems the clinician obtains by asking a series of questions to identify signs and/or symptoms the patient may be experiencing or has experienced. Depending on the number of systems reviewed, an ROS can be problem pertinent, extended, or complete. For ROS purposes, the "systems" are:

- Constitutional Symptoms (for example, fever, weight loss)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/lymphatic
- Allergic/immunologic

A ***problem pertinent ROS*** looks into the system directly related to the problem identified in the HPI. An ***extended ROS*** involves the system directly related to the problem(s) identified in the HPI as well as two to nine additional systems. A ***complete ROS*** inquires into the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of ten) organ systems.

The past, family, and/or social history (PFSH) component consists of a review of:

- Past history, including illnesses, operations, injuries, and treatments
- Family history, including review of medical events, diseases, and hereditary conditions that may place the patient at risk
- Social history, including an age-appropriate review of past and current activities

A clinician performing a ***pertinent PFSH*** must conduct a review of the history areas directly related to the problem(s) identified in the HPI and document at least **one** item from any of the three history areas above. A **complete PFSH** entails review of all three history areas when the services include a comprehensive assessment or reassessment of the patient, and two history areas for other services.

Based on the four elements of the "history" component of an E&M visit, the history type can be identified as follows:

- **Problem focused history** – documentation of the chief complaint (CC) and a brief history of present illness (HPI).
- **Expanded problem focused history** – documentation of the CC, a brief HPI, and a review of systems (ROS) relevant to the presenting problem.

- **Detailed history** – documentation of the CC, an extended HPI, plus an extended ROS, and pertinent past, family, and/or social history (PFSH) or minimum of three chronic/inactive conditions reviewed.
- **Comprehensive history** – documentation of the CC, an extended HPI, complete ROS, and complete past, family and social history.

EXAM

FLS programs should be aware that documentation of the exam component will depend on whether the facility uses the 1995 or the 1997 version of documentation guidelines. A guidelines crosswalk is provided at the end of this section.

The levels of the Exam component of E&M services are, like the History component, based on four types of examination:

- **Problem Focused Exam** – Include performance and documentation of one to five elements identified by a bullet in one or more organ system(s) or body area(s) if general/multi-system.
- **Expanded Problem Focused Exam** – A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s). This includes performance and documentation of at least six elements identified by a bullet in one or more organ system(s) or body area(s).
- **Detailed Exam** – An extended examination of the affected body area(s) or organ system(s). and any other symptomatic or related body area(s) or organ system(s). For single organ system exams, include performance and documentation of at least twelve elements identified by a bullet. Multi-system exams should include either (1) at least six organ systems or body areas with performance and documentation of at least two elements identified by a bullet; or (2) performance and documentation of at least twelve elements identified by a bullet in two or more organ systems or body areas.
- **Comprehensive Exam** – A general multi-system examination or complete examination of a single organ system. A general multi-system exam should include at least nine organ systems

or body areas. For single system exams, clinicians should include performance of all elements identified by a bullet, whether in a shaded or unshaded box.

MEDICAL DECISION MAKING

The medical decision-making component of an E&M service seeks to capture the complexity of establishing a diagnosis and/or selecting a management option. The factors driving complexity are:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

The table below outlines the four types of medical decision making (MDM) and the elements required for each. To qualify for each type, the MDM must meet or exceed two of the three elements.

TYPE OF DECISION MAKING	NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS	AMOUNT AND/ OR COMPLEXITY OF DATA TO BE REVIEWED	RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

FLS programs will encounter varying levels of complexity based on the characteristics of each patient. It is important to ensure that the documentation supports the level of complexity identified. The complexity of data could include considerations of the diagnostic services ordered, planned, scheduled, or performed at the time of the E/M encounter, review of laboratory, radiology, and/or other diagnostic tests, and decisions on whether to obtain medical records or additional history from other sources. In assessing risk, documentation should include the comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality.

The table on the following page illustrates how the components of E&M services work together to aid clinicians and billing staff in selecting the appropriate code.

Add-on codes reimburse clinicians for time spent in excess of that expected for the appropriate E&M code.

OFFICE OR OTHER OUTPATIENT SERVICES		
	1995 GUIDELINES	**1997 GUIDELINES**
99201 (new Pt) **99211 (established)**	**History:** CC; brief HPI **Exam:** Limited exam of affected body area/ organ system **MDM:** Dx/management options minimal; amount/complexity data- minimal or none; risk-minimal	**History:** Same **Exam:** one–five bullet elements in one or more organ systems or body areas **MDM:** Same
99202 (new Pt) **99212 (established)**	**History:** CC; brief HPI; problem pertinent ROS **Exam:** Limited exam of affected body area/ organ system & other related/symptomatic system(s) **MDM:** Dx/management options-minimal; amount/complexity data-minimal or none; risk-minimal	**History:** Same **Exam:** Six bullet elements in one or more organ systems or body areas **MDM:** Same
99203 (new Pt) **99213 (established)**	**History:** CC; extended HPI; problem-pertinent ROS including review of limited number additional systems; pertinent PFSH directly related to problem(s) **Exam:** Extended exam of affected body area(s)/organ system(s) and other related/ symptomatic system(s) **MDM:** Dx/management options-limited; amount/complexity data-limited; risk-low	**History:** Same. Document two–nine systems for ROS. PFSH should document one item from any history area **Exam:** Two bullet elements in at least six organ systems/ body areas OR 12 bullet elements in two or more organ systems/ body areas. Single System-Eye or Psychiatric Exams: nine bullet elements are required **MDM:** Same
99204 (new Pt) **99214 (established)**	**History:** CC; extended HPI; ROS directly related to problem(s) plus review of all additional systems; complete PFSH **Exam:** General multisystem exam or complete exam of a single-organ system, basing exam on the seven recognized body areas and/or the 11 recognized organ systems **MDM:** Dx/management options-multiple; amount/complexity data-moderate; risk-moderate	**History:** Same. Document at least four elements of HPI or document at least three chronic/inactive conditions. ROS should document at least 10 organ systems **Exam:** All bullet elements in at least nine organ systems/body areas. Document no less than two bullet elements in each area/system reviewed. Single-System Exams: Must document all bullet elements in shaded boxes and at least one bullet element in each unshaded box **MDM:** Same
99205 (new Pt) **99215 (established)**	**History:** CC; extended HPI; ROS directly related to problem(s) plus review of all additional systems; complete PFSH **Exam:** General multisystem exam or complete exam of a single-organ system, basing exam on the seven recognized body areas and/or the 11 recognized organ systems **MDM:** Dx/management options-extensive; amount/complexity data-extensive; risk-high	**History:** Same. Document at least four elements of HPI or document at least three chronic/inactive conditions. ROS should document at least 10 organ systems **Exam:** All bullet elements in at least nine organ systems/body areas. Document no less than two bullet elements in each area/system reviewed. Single-System Exams: Must document all bullet elements in shaded boxes and at least one bullet element in each unshaded box **MDM:** Same

PROLONGED SERVICES WITH DIRECT PATIENT CONTACT

When a physician or other qualified health care professional provides prolonged service(s) involving direct patient contact that is provided beyond the usual evaluation and management (E/M) service, the following codes can be included on the claim in addition to the primary E&M service:

CPT 99354 - Prolonged E/M in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour
CPT 99355 - Each additional 30 minutes (list separately in addition to code for prolonged service)

PROLONGED SERVICES WITHOUT DIRECT FACE-TO-FACE PATIENT CONTACT

Clinicians can also obtain reimbursement when a prolonged service is provided that is neither face-to-face time in the office or outpatient setting, nor additional unit/floor time in the hospital or nursing facility setting during the same session of an E & M visit if it is beyond the usual physician or other qualified health care professional service time. This would be a relatively rare occurrence within most FLS programs, and these codes should be used only when the patient's condition justifies prolonged service and those services are performed and documented.

The codes below can be reported in conjunction with any level of E&M service and may be reported on a different date than the primary service to which it is related.

CPT 99358 - Prolonged E/M before and/or after direct patient care; first hour
CPT 99359 - Each additional 30 minutes (list separately in addition to code for prolonged service)

CHRONIC CARE MANAGEMENT

Medicare covers chronic care management services if a patient has two or more serious conditions that are expected to last at least a year. For 2020 and later years, CMS added codes that enable clinicians to bill for chronic care management in patients with one chronic condition. Osteoporosis qualifies as a chronic condition.

The proposed addition of "Principal Care Management" codes would apply to comprehensive care management services for a single high-risk disease, e.g., Principal Care Management, at least 30 minutes of physician or other qualified health care professional time per calendar month.

Services for principal care management should meet the following requirements:

- One complex chronic condition lasting at least 3 months, which is the focus of the care plan,
- Condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization,
- Condition requires development or revision of disease-specific care plan,
- Condition requires frequent adjustments in the medication regimen, and/or
- Management of the condition is unusually complex due to comorbidities.

CODE	NATIONAL PAYMENT, NON- FACILITY RATE	CLINICAL STAFF TIME	CARE PLANNING	BILLING PRACTITIONER WORK
99490	$42	20 minutes	Established, implemented, revised or monitored	• Ongoing oversight, direction and management. • Assumes 15 minutes of work
99487	$93	60 minutes	Established or substantially revised	• Ongoing oversight, direction, and management • Medical decision making of moderate-high complexity • Assumes 26 minutes of work
+99489	$46	30 minutes	Established or substantially revised	• Ongoing oversight, direction, and management • Medical decision making of moderate-high complexity • Assumes 14 minutes of work
G0506	$63		Established	• Extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

Medicare also provides payment for care planning at initiation of CCM.

G0506 should be reported to report comprehensive assessment and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)

KEY POINTS ON APPROPRIATE USE OF CCM CODES:

- Requires care plan development for a chronically ill patient at an initiating visit for new patients or patients not seen in one year

- The initiating visit and an add-on code may be billed at the start of chronic care management
- Clinical staff, under the general supervision of a physician or NPP, provides and documents non-face-to-face care coordination during a calendar month
- Requires 24/7 access for urgent care needs
- Patient must consent to the service, and there is a patient due co-pay
- While typically non-face-to-face services, there may be educational or motivational counseling that is provided face-to-face and this may be included in the clinical staff time
- Time may never be counted twice to report two different services.

FLS STAFF CODES FOR INTERACTION WITH PRIMARY CARE PROVIDER – INTERPROFESSIONAL TELEPHONE/INTERNET CONSULTATION (ITC)

CMS recently extended payment to six codes that describe assessment and management consultative service provided by phone, internet or electronic health record when the patient's treating physician/non-physician practitioner (NPP) requests an opinion and/or treatment advice of a consulting physician/NPP. The consulting physician/NPP would be the practitioner with specific specialty expertise to assist in the diagnosis and/or management of the patient, without a face-to-face visit.

The clinician requesting the consultant's expertise must obtain verbal consent for the interprofessional consultation from the patient/family and must document that the consent was given in the patient's medical record.

The ability to bill for this service can be helpful for FLS programs in situations such as:

- The patient lives far enough away from the FLS center that it is not practical to return to the clinic for osteoporosis treatment and follow-up;
- The patient prefers to receive care from their primary care clinician;

- A treating clinician who is a PA/NP consults with a physician on a FLS patient;
- The FLS is part of a larger health system and/or operates on a hub-and-spoke model.

These codes can also be used when a FLS is within a larger entity with satellite locations in the community. The codes are typically reported when a new problem arises or a chronic issue is not well-managed or exacerbates. Osteoporotic fracture and/or poorly managed bone fragility would qualify for these codes. The codes listed in the table below apply to consulting clinician services that comply with the following requirements:

- Consultant may not have had a face-to-face service with the patient in the last 14 days
- May not bill if review leads to a face-to-face service with the patient in the next 14 days
- Majority of the time must be medical consultative verbal or internet discussion (greater than 50%)
- Codes are not reported more than once in a 7-day period
- Codes are not used for a transfer of care
- Written or verbal request should be documented in the patient's medical record, including the reason for the consult

CODE	DESCRIPTION
99446	Interprofessional telephone/Internet/electronic health 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	11-20 minutes of medical consultative discussion and review
99448	21-30 minutes of medical consultative discussion and review
99449	31 minutes or more of medical consultative discussion and review
99451	Interprofessional telephone/Internet/electronic health 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 minutes of medical consultative discussion and review

CPT code 99451 is used to report interprofessional telephone/Internet Electronic Health Record Consultations by a treating physician or other qualified health care professional. This clinician is the "requestor."

- Use for time of 16-30 minutes in a service day preparing for the referral and/or communicating with the consultant;
- May not be reported more than once in a 14-day period;
- May report face-to-face prolonged care codes with this service if an E/M service is also provided and the time exceeds 30 minutes beyond the typical time;
- If the patient is not present, may report non-face-to-face prolonged codes if the time spent in the day exceeds 30 minutes.

FOR BRIEF "REMOTE" FOLLOW-UP ON PATIENTS RECEIVING TREATMENT (EITHER BETWEEN OFFICE VISITS OR IN LIEU OF A FOLLOW-UP VISIT) – VIRTUAL CHECK-INS. (HCPCS G2012)

FLS centers can find it challenging to follow up with patients to ensure that their medication is well-tolerated and that they are taking it as directed. Office visits can be helpful, but some patients can be managed through telephone contact. Historically, CMS has not made separate payment to physicians for patient telephone calls that evaluate whether an office visit or other service is warranted. If the physician decided to see the patient, CMS considered the check-in as bundled into the payment for the resulting visit. When the check-in did not lead to an office visit, the clinician received no payment for the time and effort associated with the call.

CMS acknowledged the problems this reimbursement model creates and that the evolving technological landscape is such that it is appropriate to address these misaligned incentives and pay for virtual check-ins under HCPCS G2012.

The reimbursable service is, however, narrowly defined and the reimbursement is set at a better-than-nothing level of approximately $15.00.

- There are no frequency limits on this code;
- The discussion check-in is generally brief, e.g., 5-10 minutes;
- Virtual check-in must be with a physician or other qualified healthcare professional;
- The check-in would not originate from a related E/M service provided within the previous 7 days;
- Cannot bill this code if it leads to an E/M service or procedure within the next 24 hours (or soonest available appointment).

CMS has also clarified "that telephone calls that involve only clinical staff [cannot] be billed using HCPCS G2012, since the code explicitly describes (and requires) direct interaction between the patient and the billing practitioner.

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