Quick Reference Guide:
Making Care Primary e-Consult (MEC) Code

Background

For the first time in an advanced primary care model, Making Care Primary (MCP) will directly equip participating primary care organizations with tools to improve care coordination with high-quality specialists through access to data dashboards, Collaborative Care Arrangements (CCAs), model-specific interprofessional consultation, and co-management billing privileges. Beginning in Track 2, participants will have access to a new **MCP e-Consult (MEC) code** for all MCP-attributed beneficiaries. Track 2 participants will also identify high-quality Specialty Care Partners and MCP Specialists and establish expectations for coordination, through CCAs or collaborative protocols, respectively. Track 3 participants will enhance specialty relationships and introduce a new Ambulatory Co-Management (ACM) code to be used by specialist partners.

What is the Make Care Primary e-Consult (MEC) Code?

The MEC code (G9037) is a new MCP-specific code billable by MCP clinicians for MCP-attributed beneficiaries. When providing care to a patient or determining a treatment plan, it may be beneficial for a primary care provider to consult a specialist. The MEC will be valued at the same level as the existing requesting physician interprofessional consultation (IPC) code (99452), including geographic adjustments and facility and non-facility adjustments. However, to address current barriers to utilizing the current IPC codes, CMS is creating this new model specific code which includes post-service time in the time requirements (see example clinical vignettes below). Payment for the MEC code is set at $40 per service subject to the geographic adjustment factor (GAF) and subject to all Medicare payment adjustments and penalties to which the MCP clinician's other Medicare FFS payments are subject. Specialty partners responding to the e-consult may use any of the appropriate existing IPC codes.

What is an e-consult?

An e-consult is a technology solution inclusive of phone, video, HIPAA-compliant application, or Electronic Health Record enhancement that allows two-way communication between primary care clinicians and specialists and can securely share patient records. This is typically an asynchronous, provider-to-provider communication about a patient's chief complaint or current condition that leverages the expertise of a specialist. To note, an e-consult is distinct clinical work from pre-visit planning for the subsequent Evaluation & Management visit.

What are the requirements for billing the MEC[1] code?

The MEC code:

- Can be billed by MCP clinicians of an MCP participant in Track 2 or Track 3, furnishing services to an MCP beneficiary.
- Can be billed for an e-consult with any specialist, regardless of whether the consulting specialist is one with whom the primary care clinician has a Collaborative Care Arrangement (CCA).
- Can only be billed once per consultation (or clinical question) with the specialist, no matter how many times the MCP clinician and specialist exchange information.

[1] Please refer to the Participation Agreement for the full parameters and requirements of the MEC code

- Cannot be billed more than once per week per MCP beneficiary, regardless of how many consultations the MCP clinician has concerning the MCP beneficiary.
- Cannot be billed on the same day as the IPC code (99452) for the same MCP beneficiary by the same MCP clinician.

Example Clinical Vignettes

Vignette 1: An MCP beneficiary is seen by their primary care physician (PCP) who hears a heart murmur and orders an echocardiogram. The echocardiogram is read by a cardiologist who includes a line on the report that the primary care physician is unfamiliar with (e.g. 'Lambl's excrescence was identified on the aortic valve). Because the PCP is concerned about this unknown finding they would typically send the patient to the cardiologist to review the finding, but instead they send an e-consult to an MCP Specialty Care Partner cardiologist who reassures the PCP that this is an extremely rare but benign finding. The PCP calls the patient to discuss that their finding on the echo is nothing they need to worry about. The MCP clinician bills the MEC code after speaking with the patient to relay the results of the echo finding, which includes the time they spent writing their question (e.g. "What is Lambl's excrescence? Does my patient need another echocardiogram or any other testing?"), the time interpreting the response from the cardiologist, and the time discussing this finding with their patient. This is only if they are not communicating this finding to the patient in a subsequent outpatient visit. If the patient prefers to discuss with the clinician at their next visit, this time would count as pre-visit time for the subsequent E/M.

Vignette 2: An MCP beneficiary is seen by their PCP (at an MCP practice) and they have knee osteoarthritis and standing Tylenol with intermittent NSAIDs. The patient also suffers from chronic depression managed with an SSRI prescribed by their psychiatrist. The PCP would like to consider switching the patient to duloxetine, an SNRI, however the patient's psychiatrist has not been reachable by phone. The PCP sends an e-consult to the psychiatrist with the clinical question ("given this patient's longstanding management of their depression with an SSRI, I am reluctant to suggest they switch to an SNRI for the added benefit of treating their osteoarthritis but would like your opinion.") The psychiatrist answers that the patient's condition has been extremely challenging to manage so they would suggest not switching from an SSRI to an SNRI, despite the potential OA-treating benefits of duloxetine. The MCP clinician calls the patient to suggest further topical measures and schedules the patient for a corticosteroid injection instead. The MCP clinician bills the MEC code.