

The Changing Face of Ambulatory Medicine— Reimbursing Physicians for Telephone Care

**American College of Physicians
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The Changing Face of Ambulatory Medicine—Reimbursing Physicians for Telephone Care

Part 2 of a Series of ACP Policy Papers Seeking Fair Reimbursement for Physician Care Rendered to Patients outside of the Doctor's Office

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I. Executive Summary

This is the second in a series of American College of Physician (ACP) policy papers that examines how rapid advances in communication technology are changing the face of how medicine is practiced. The first policy paper focused on how computers and the Internet could be used to streamline and enhance patient–physician communications (1). Though the potential for electronic consultations and oversight of patients is great, with a few insurers now experimenting with paying for such non–face-to-face care, only a very small proportion of patients and physicians are availing themselves of this new technology, with the vast majority still relying heavily on the telephone. This is particularly true during evenings and weekends, when the telephone is the primary tool that patients have for reaching their physicians.

This second policy paper focuses on how telephones—an older, more familiar form of technology—could be better utilized to serve more patients and increase physician productivity, while at the same time driving down escalating health care costs. Telephone care has long been established as a substitute for face-to-face care, which, when used appropriately, can improve patient health status and reduce mortality (2). The major impediment to such usage is the unwillingness of payers, both public and private, to pay physicians for care rendered over the telephone—at great detriment and cost to patients and the health care system at large.

Patients still primarily contact their physicians in one of two ways—through a face-to-face office visit or by telephone. When it comes to providing a high level of service to patients, the telephone is still one of the most powerful tools in a physician’s arsenal. If used properly, the telephone can also be a powerful weapon in helping to restrain escalating health care costs by preventing unnecessary and expensive emergency room visits and allowing many patients to be treated without a costly office visit. The telephone can also help physicians to optimize their productivity in serving patients, allowing them to treat a wide array of nonurgent conditions and needs by phone without the time and expense of an office visit, while reserving face-to-face care for patients most in need.

Though physicians’ professional expertise is called upon every time they dispense care over the telephone, placing themselves at full legal risk when doing so, they are, with few exceptions, paid nothing for their services, time, and liability exposure. Instead, the fiscal incentive is to encourage patients to come into the office for even the most minor of conditions and bill the government, third-party payers, and/or patients at a rate that would far exceed what might be charged for a relatively brief phone encounter. Clearly, the reimbursement system is antiquated, creates improper financial incentives, and is in need of a change.

In short, it is time to start paying physicians for all the care they render to patients, including by telephone, and start honoring the work, expertise, and risk that such care represents. In the long run, all parties will benefit: Physicians will be able to treat more patients and use their time more productively; patients’ satisfaction should rise as their access to their physicians is increased and they avoid workdays lost for unnecessary office visits; and health insurers will pay less overall by reducing the number of unnecessary emergency room and doctors’ office visits. Therefore, ACP recommends the following:

Recommendation 1:

The American College of Physicians (ACP) supports reimbursement by Medicare and other payers for health-related communications, consultations, and other appropriate services by telephone, subject to guidelines on the level of work required for the service to be reimbursed as a separate service outside of the usual evaluation and management (E/M) service.

Recommendation 2:

Medicare and other payers should work with the physician community to develop guidelines on reimbursement of health-related communications, consultations, and other appropriate services via the telephone. The guidelines should include examples of both reimbursable and nonreimbursable telephone-related communications.

Recommendation 3:

Payment for health-related telephone communications should not result in a reduction in separate payments for E/M services.

II. Introduction

Many professional services, such as the provision of legal and medical advice, can be rendered with high quality and efficiency via telephone. Telephone medical care requires a high level of professional assessment and judgment, entails practice expenses and malpractice risks, and provides a substitute for costly office and/or emergency department visits. Despite these characteristics, telephone care is generally not reimbursed, either by the government or by health care plans. It is the position of ACP that telephone services that are reasonable, properly documented, and of high quality are billable services that merit reimbursement by patients and third parties, including Medicare, Medicaid, and private insurers. Telephone care has long been established as a substitute for face-to-face care, which, when used appropriately, can improve patient health status and reduce mortality (2).

Physicians traditionally have provided extensive telephone care to patients, typically without reimbursement. Patients rely heavily on the telephone as a lifeline to their physicians after office hours and on weekends. A July 2000 MSNBC report stated the following: “Telephone calls make up 15 to 28% of encounters between doctors and patients, according to several studies. . . . that number can rise to 48%” (3). This high level of telephone contact between patients and physicians is further underscored in a May 2000 *Journal of General Internal Medicine* article that states the following: “Primary care physicians receive an estimated 150 to 300 calls per week, of which about half deal with clinical issues. In general internal medicine practice, 25% of patient contacts are made via the telephone, which is second only to the proportion in pediatrics” (4).

Thus, it is clear that physicians are expending a sizable portion of their workday, as well as after-office hours, rendering uncompensated care. Except as part of Care Plan Oversight for home health and hospice patients (5), Medicare does not reimburse separately for physician telephone services. The Medicare program’s administrator, the Centers for Medicare and Medicaid Services, currently prohibits physicians from submitting additional charges for physician telephone services to Medicare patients. In essence, Centers for Medicare and

Medicaid Services considers provision of telephone care to be already bundled into payment for physician care. This Medicare policy is detailed in Section 2020 B of the *Medicare Carriers Manual*:

Telephone Services.—Services by means of a telephone call between a physician and a beneficiary, or between a physician and a member of a beneficiary's family, are covered under Medicare, but carriers may not make separate payment for these services under the program. The physician work resulting from telephone calls is considered to be an integral part of the prework and postwork of other physician services, and program payment for the latter services already includes payment of the telephone calls (6).

There are also very few third-party payers that reimburse physicians for telephone care, while most managed care systems consider this service already included in payments made to physicians. ACP policy contends, however, that coding and billing for telephone services ideally should not vary according to the third-party payer involved. Physicians should be allowed to apply a uniform policy to Medicare, Medicaid, privately insured, and uninsured patients.

This failure to reimburse physicians for their time and knowledge rendered to patients over the telephone is totally incongruent with the reimbursement practices of many other professions. For example, it is established and accepted practice for attorneys to charge for telephone services. Business consultants also charge for their time, regardless of whether their services are rendered in person or not.

This paper urges Centers for Medicare and Medicaid Services and other insurers to take note of the great value and impact that telephone care of patients has had, in terms of conserving and more effectively utilizing precious health care funds and allowing physicians to more efficiently serve their patients, reserving office visits only for those patients who truly need face-to-face care. By paying for medically justifiable telephone care of patients, all parties benefit. Physicians, for example, can spend more time serving their patients, yielding a happier and healthier patient population, while the government and private insurers save money by averting sometimes costly and unnecessary face-to-face office visits or unwarranted visits to the emergency room.

III. Appeal and Benefits of Providing Telephone Care

The ACP believes that use of the telephone to provide patient care is appealing and beneficial for a number of reasons, including the following:

1. Increased Practice Efficiency and Productivity and Lowered Operating Costs

Many health care decisions can be made safely over the telephone, avoiding the time and cost of an in-office visit and saving the patient and health care system both time and money; making physicians more productive; and reserving face-to-face care for the most needy patients.

2. Increased Patient Access, Satisfaction, Retention, and Practice Growth

Telephones allow patients to reach physicians at all times, around the clock, even when the physician is not in the office. This can be an important factor in increasing patient satisfaction, retention, and practice growth.

3. Necessary Office Visits Are Made More Productive and Less Time Consuming

Obtaining important clinical information by telephone before an office visit can save time and make the face-to-face encounter more productive. This also translates to less-cluttered waiting rooms, shortened waiting times, and more satisfied patients.

4. Rapid Transmission of Vital Patient Information

Telephones permit immediate transmission of medical information by voice or fax.

5. Allows for Frequent Contacts Needed for Oversight of Chronically Ill Patients

Many patients with chronic diseases require multiple physician contacts. Many of these contacts do not require a face-to-face encounter and could easily be accomplished by telephone contact from the physician.

IV. Concerns and Obstacles to Widespread Adoption and Reimbursement of Telephone Care

Providing care over the telephone creates a set of challenges, costs, and risks that, though not insurmountable, are worthy of careful consideration. It is clear that provision of effective and safe telephone care represents a substantial tap on office resources and physician work and time, warranting additional reimbursement. Such efficacious use of the telephone requires that patient telephone calls are appropriately triaged by trained medical staff (some offices use automated telephone systems to avoid critical omissions) and that all clinically significant information is collected and fully documented in the medical record, which is vital for assuring proper diagnosis and treatment, as well as for justifying payment for such care. Errors in telephone management can have severe consequences, as telephone patient contacts are legally no different from office visits in terms of physician-patient obligations. In a climate where patient safety and reduction of medical errors has become a national priority, it is critical that telephone care be given all the safeguards necessary to protect patients' well-being.

Another concern for physicians is the potential for misuse by the patient. Such situations must be handled on a case-by-case basis by the physician. If reimbursement for patient calls is ever implemented, it is important to note that data suggest that requiring patient copayment "may reduce patient use of outpatient care for minor symptoms while preserving appropriate use for serious symptoms" (7).

To reduce their risk of liability, it is essential that physicians assure full and complete documentation of calls with patients. This can be achieved through use of standardized encounter forms, along with written guidelines and protocols for handling and documenting patient calls. It is crucial that staff be well trained so they fully understand their responsibilities and can assure appropriate triage, with physician consultation always available for backup. The goal is to assure that the system of handling patients' calls is timely and effective and does not create problems or delays that lead to untoward health outcomes for patients.

To garner support for reimbursement of telephone care, it is vital that the medical community develop objective data substantiating the nature, volume, and time expended rendering care by telephone, showing the complexity of decision making and final disposition of each call. Public and private payers are only likely to begin paying for this service when it can be shown to be cost effective and that there is true demand from patients and physicians alike.

It is also vital that medical schools, residency programs, and continuing medical education programs incorporate training on diagnosis and treatment of patients by telephone, recognizing the telephone's great potential to serve a wider array of patients effectively, helping to reserve office visits for those most in need and to lower overall health system costs.

V. Guidelines for Reimbursing Telephone Care

These guidelines identify situations where the medical expertise called upon and decision-making complexity justify payment for physician services rendered by phone. The appropriate American Medical Association Current Procedural Technology case management telephone service code (99361-99373) (8) should be determined according to the level of service rendered. The charge should be based on the time, intensity, and complexity of the call.

Patients should be informed of policy or guidelines adopted by the physician concerning telephone service charges, including what types of services merit a charge, general or specific details of the charge amounts, as well as an explanation that charges have been made.

A. Examples of Reimbursable Telephone Services:

1. Services that involve a new diagnosis or require a new treatment (e.g., acute respiratory illness), when the equivalent service performed in person would have led to a service charge itself.
2. Patient maintenance services, such as management of insulin-dependent diabetics with multiple blood-sugar checks and insulin changes.
3. Treating relapses of a previous condition when this can be adequately assessed by phone, but a significant investment of physician time and judgment are involved (e.g., irritable bowel; asthma; congestive heart failure; flare-up of gout).
4. Reporting laboratory results (for laboratory work not done in conjunction with an office visit) that require a significant change in medication or further diagnostic tests (e.g., adjustment of warfarin after a prothrombin time is done; addition of a second drug when treating hyperlipidemia; or ordering gallbladder studies when liver functions are abnormal on routine studies).
5. Extended personal counseling by telephone when the specific situation is of an urgent nature, where a physical exam is not essential or necessary to perform the service, and where failure to perform the service could lead to patient harm.

Examples:

- a. An established patient with acute exacerbation of a severe anxiety disorder or depression, commonly involving discussion of medications or recommended psychotherapy needs, mental status and mood assessment, and recommendations for further immediate care.
 - b. A test result entails a referral for a significantly complex procedure, with the potential for morbidity, complex preparation, and/or hospitalization; however, the discussion, consent, and instructions do not require a face-to-face encounter (e.g., breast lump found on mammogram; positive treadmill entails a cardiology referral and possible angiogram; patient refusal of a test or treatment previously discussed in detail necessitates further discussion and counseling).
6. Nursing or rest home calls when the patient has a significant change in condition, such as a change in vital signs, respiratory infection, or fall.
 7. Extended counseling with family when done by telephone (e.g., cases in which there are significant intrafamily conflicts or deficits in understanding related to a patient under direct care).

Please note: If another E/M service is performed that is essentially incidental to the condition treated by telephone, there should not be separate service charges engendered.

If a variety of personal contacts is involved (with the patient, caregiver, or other health care workers) and/or if multiple forms, reports, and laboratory reports are required, then use of the case management Current Procedural Technology would be more appropriate. These codes cover medical conferences by a physician with the beneficiary, relatives, health professionals, and/or representatives of community agencies. If one or several complex forms are required without significant telephone contact or direct contacts with other health personnel, use of the Current Procedural Technology code 99080 (involving completion of special reports, such as insurance forms, or the review of medical data to clarify a patient's status beyond what would be conveyed in usual medical communications or standard reporting form) would be more appropriate.

B. Documentation Requirements

All telephone services that are billed should be fully documented in the patient's chart. Documentation should include the date of the call, reason for the call, diagnosis, treatment given, involved parties (other than the patient), and follow-up instructions.

VI. ACP Recommendations Regarding Payment for Telephone Care

ACP believes that physicians render a substantial amount of care to patients over the telephone and that this represents a professional service worthy of reimbursement. This leads ACP to make the following recommendations:

Recommendation 1:

The American College of Physicians (ACP) supports reimbursement by Medicare and other payers for health-related communications, consultations, and other appropriate services by telephone, subject to guidelines on the level of work required for the service to be reimbursed as a separate service outside of the usual E/M service.

Recommendation 2:

Medicare and other payers should work with the physician community to develop guidelines on reimbursement of health-related communications, consultations, and other appropriate services via the telephone. The guidelines should include examples of both reimbursable and nonreimbursable telephone-related communications.

Recommendation 3:

Payment for health-related telephone communications should not result in a reduction in separate payments for E/M services.

VII. Conclusion

The quality of patient care relies heavily on patients' having timely access to their physicians. Telephone contact between patient and physician plays a vital role in assuring that patients' health care needs are met in a timely fashion. It enables physicians to be far more efficient and productive, while helping to reserve face-to-face care for those patients most in need. Thus, both patients and physicians can benefit, as unnecessary office visits can be avoided—saving patients not only the cost of the visit but possibly a lost day at work. But this can work optimally only if physicians are, like their many nonmedical professional counterparts, duly compensated for the services they render over the phone.

ACP believes that properly triaged and documented telephone care has great potential for lowering health system costs and increasing physician productivity and patient satisfaction. Yet this potential will never be fully realized until the federal government and insurers recognize that telephone care is not only legitimate and efficacious but can save health care dollars, as well.

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Other Resources

Telephone Medicine: A Guide for the Practicing Physician, Edited by Anna B. Reisman, MD, and David L. Stevens, MD

This book is available from ACP and provides clinicians with a solid understanding of what telephone medicine is and the many ways it can improve patient care. Primary care physicians, in particular, will benefit from the emphasis on evidence-based approaches to telephone management of common symptoms, such as chest and abdominal pain, sore throat, headache, and depression. Other topics include communication skills, medicolegal issues, difficult patient types, documentation, and office management.

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