Getting Paid for Telephone Care

Andrew R. Hertz, MD, FAAP
Medical Director, Rainbow Call Center
Medical Director, Suburban Pediatrics
Chair, Section on Telehealth Care
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Part I – Understand that Telephone Care is Good Medicine

Part II – Learn the CPT Codes for Telephone Care

Part III – Learn how to Charge for Telephone Care in your Practice

Part IV – Understand how to Argue the Business Case for Telephone Care to Payers
Part I

Telephone Care is Good Medicine

- Triage and Advice
- Disease and Case Management
- Medication Adjustments
- Acute Illness Care
- Test Result Interpretation
- Counseling
- Patient Education
Pediatric Telephone Care

- 2,000-3,000 calls/yr/MD
- 10-15 clinical calls/day/MD
- 27% of decisions to see a specialist made over the phone
- Significant chronic care disease management done over the phone
Reasons for Increasing Use of the Telephone

- Ease – everyone is attached to a cell phone
- Convenience – no waiting in the office
- Safe
- Dual-working families
- Doctors pushed to see more patients
Goal of study to assess:

(1) frequency of death or potential under-referral associated with hospitalization within 24 hours after a call, and
(2) factors associated with potential under-referral.

Results:

- No deaths occurred within < 1 week after the after-hours calls.
- Rate of potential under-referral with subsequent hospitalization was 0.2%, or 1 case per 599 triaged calls

Cost of MD Taking Clinical Calls

Direct Costs
$7,000 per pediatrician/yr
If other staff takes calls, increased expense

Opportunity Costs
MD takes 3-5 min (avg. 4) to answer each call
Non-reimbursable time
MD bills approximately $360/hr (conservative) or $6.00/min
Opportunity cost of MD doing triage is $240-$360 per day or at least $60,000/yr
The provision of after-hours telephone care results in an average savings for payers of $56 per call

Pediatrics 2007; 119: e305-e313

The provision of physician telephone care to those patients a nurse refers to an ED (SLT) decreases the number of ED visits by 50% leading to savings for payers.

Reducing After-Hours Referrals by an After-Hours Call Center With Second-Level Physician Triage
Coded for Telephone Care
How we got here in a nutshell

• AAP Policy Statement 2006
• Development of New CPT Codes 2007
• Assignment of RVUs 2007
• Codes and Values Launched in 2008!!
AAP supports payment for telephone care services provided by pediatric providers triage and advice, care coordination, patient education, and chronic disease management.

Pediatrics 2006; 118: 1768-1773
Telephone Services 2008 “New and Improved”

- Have times in code descriptors allowing correct selection of level
- Global period for telephone care as part of pre and post visit care has been limited and “unbundled” from other E/M codes
- Codes have been “valued” by CMS, though not paid by CMS

**Non-facility RVU**

<table>
<thead>
<tr>
<th>Code</th>
<th>Time Range</th>
<th>RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99441</td>
<td>5-10 min</td>
<td>0.36</td>
</tr>
<tr>
<td>99442</td>
<td>11-20 min</td>
<td>0.66</td>
</tr>
<tr>
<td>99443</td>
<td>&gt; 20 min</td>
<td>0.98</td>
</tr>
</tbody>
</table>
Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment;

99441 5-10 minutes of medical discussion
99442 11-20 minutes
99443 over 20 minutes
1. Telephone services are non-face-to-face evaluation and management (E/M) services provided by a physician to a patient using the telephone.

2. These codes are used to report episodes of care by the physician initiated by an established patient or guardian of an established patient.

3. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure, and visit.
4. Likewise if the telephone call refers to an E/M service performed and reported by the physician within the previous 7 days (either physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure.

5. **Do not** report 99441-99443 if reporting 99441-99443 performed in the previous 7 days for the same diagnosis.
Care Plan Oversight – patient not under the care of a home health agency, hospice, or nursing facility

99339 – Individual physician supervision of a patient in home… (or other location)… requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans…communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s)…involved in the patient’ scare…adjustment of medical therapy, within a calendar month; 15-29 minutes

99340 - >30 minutes

Need a tracking system!
Non-Physician Qualified Health Care Professionals

98966: Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

98967: 11-20 minutes of medical discussion

98968: 21-30 minutes of medical discussion
The Rules

Clinical staff (eg, registered nurses) may appropriately report codes 98966-98968 as long as:

1) The service provided falls within the state scope of practice laws for that qualified health care professional;

2) Established practice protocols are followed;

3) The physician assumes responsibility for the practice expense, quality, and professional liability of the telephone service provided, whether by employing the clinical staff or via a legal contract with a telephone advice entity;

4) The patient is established; and

5) All patient charges originate only from the physician's office.
Part III
How Do You Get Started?
AAP Payment for Telephone Toolkit

• Useful tools for near turnkey implementation
• Provides a handy Timeline to ‘Going Live”
• Free download to AAP members on Practice Management Online website
• Arguments to assist with educating payers
• Accessed over 13,000 times!!
Charging for Calls in Your Office

Step 1  Decide for what type of calls you will charge
Step 2  Evaluate contracts, decide on waivers
Step 3  Notify patients, payers*  KEY STEP
Step 4  Document and code
Step 5  Bill and collect, appeal denials
Possible Types of Calls

- Office-hours vs. After-hours
- Nurse vs. Doctor, or both
- Urgent, Emergent vs. Non-Urgent
- During certain “Telephone Care Hours”
- Types of Calls
  - Services that involve a new treatment (avoid office visit)
  - Chronic medication management
  - Chronic disease flare management
  - Reporting lab results that necessitate a management change or referral
  - Extended behavioral counseling
  - Follow-up calls to an office visit
- Timing of call in relation to office visit
  - Does not pertain to an office visit
  - Follow-up call in place of an office visit > 7 days
  - Prevents an office visit
Payment Policies Vary:

1. Bundled (CMS)-already “paid” in E/M face to face services previously billed
2. Covered – plan covers-plan pays you
3. Non-covered - patient pays you after claim is denied by payer
Notification Options

- **Letter**
  - To whom? – all patients, new patients, at identification of chronic disease, only after a billable phone call (1<sup>st</sup> one free)
  - Content – see next slide
  - How delivered – mail, with billing statement, in office by receptionist or by MD during visit

- **Office signs**

- **Office handouts/brochures** – educate on alternative information sources (web sites, books)

- **Recorded answering messages**

- **Receptionist notification at time of telephone call**
Type of calls being charged

Why being billed – explain the concept of “Telephone Care”, not just a telephone call

- Participating in a national trend to provide meaningful medical care over the telephone
- “Telephone Care” can be cheaper, not only for the patient but for insurers and employers, thereby decreasing the total cost of healthcare
- Telephone Care provides a convenience to the patient
- Telephone Care can replace some types of office visits
- Telephone Care takes physician time

Insurance coverage and patient responsibility – co-pay may apply (check your contracts)

Care will not be denied over the telephone

Patients will always have the option of seeing the physician in person
Telephone Call Documentation

**Purpose of Documentation**
- Continuity of care
- Demonstrate complexity of call
- Meet requirements of E/M visit

**Content of Documentation**
- Date and time of call, patient’s name, date of birth, reason for call, relevant history and evaluation, assessment, plan, disposition, total encounter time

**Location of Documentation**
- Chart and/or Telephone Log – must be retrievable
Billing and Collections

1. Follow normal office billing and collection processes vs.

2. Consider having patients sign a waiver for Telephone Care

3. Establish a policy on how to manage:
   - Medicaid patients
   - First time callers
   - Personal payment responsibility
   - Co-pays
Medicaid Payment for NF2F Care

1. Alaska
2. Arizona
3. Delaware
4. Mississippi
5. Nebraska
6. Nevada
7. New Hampshire
8. North Carolina
9. North Dakota

10. Oklahoma
11. Oregon
12. Rhode Island
13. South Carolina
14. Texas
15. Utah
16. Virginia
17. Washington
18. West Virginia
19. Wyoming
Humana Will pay for Telephone Care

Humana has established payment processing rules for the new telephone CPT codes 99441-99443. These codes will be processed as covered services; however, the plan member will be responsible for standard office co-payments or other cost-share amounts applicable to any other office visit. Medicare does not cover those telephone consultation codes nor does the Department of Defense (TRICARE) so neither Humana Military Healthcare Services (HMHS) nor Humana Medicare will cover the telephone care codes. Only Humana commercial health plans will provide payment for telephone care. Payment for the telephone consultation codes will be based upon the current RBRVS system.
Charging for Telephone Care Survey

Survey sent to
- Section on Telehealth Care
- Section on Ambulatory Practice Management

118 respondents
<table>
<thead>
<tr>
<th>Answer</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>25%</td>
</tr>
<tr>
<td>No</td>
<td>75%</td>
</tr>
</tbody>
</table>

- Will you begin to charge within 2 years
  - Yes 58%
  - No 42%
<table>
<thead>
<tr>
<th>Duration</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 6 months</td>
<td>15%</td>
</tr>
<tr>
<td>6-12 months</td>
<td>26%</td>
</tr>
<tr>
<td>1-2 years</td>
<td>26%</td>
</tr>
<tr>
<td>Over 2 years</td>
<td>33%</td>
</tr>
</tbody>
</table>
### Charging for - Types of Calls

<table>
<thead>
<tr>
<th>Type of Call</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians after-hours</td>
<td>62%</td>
</tr>
<tr>
<td>Physicians during office-hours</td>
<td>50%</td>
</tr>
<tr>
<td>RN after-hours</td>
<td>31%</td>
</tr>
<tr>
<td>RN during office-hours</td>
<td>8%</td>
</tr>
</tbody>
</table>
## Methods for Charging

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit to insurance using NF2F</td>
<td>60%</td>
</tr>
<tr>
<td>Submit to patients directly</td>
<td>36%</td>
</tr>
<tr>
<td>Submit to insurance using CPO</td>
<td>32%</td>
</tr>
<tr>
<td>Submit to insurance using non-physician provider NF2F</td>
<td>8%</td>
</tr>
</tbody>
</table>
**Who Paid?**

**Received any payment from source?**

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance</td>
<td>68%</td>
</tr>
<tr>
<td>Guarantor</td>
<td>76%</td>
</tr>
</tbody>
</table>
Allowable uncovered charge

Are payers allowing you to charge patients for uncovered telephone care?

Yes  33%
No   67%
How are Patients Reacting?

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients understand, are supportive</td>
<td>46%</td>
</tr>
<tr>
<td>No significant reactions</td>
<td>36%</td>
</tr>
<tr>
<td>Patients have resented, not left</td>
<td>23%</td>
</tr>
<tr>
<td>Patients have left</td>
<td>9%</td>
</tr>
</tbody>
</table>
First three month experience from a suburban practice

- 2 offices
- 9 physicians
- 5.5 FTE
- 26,000 visits per year
- MD answer all telephone calls during office hours
2008 Experience

- Followed AAP Toolkit for implementation
- 100% physician participation and planning
- Notified patients through in-office letters, signs, and personal communication
- Notification 2 months prior to implementation
- Started with low fees (below most co-pay) to assure complaints were about concept, not money, since beginning fees increased three times
- Agreed to write off first fee only if complaint
<table>
<thead>
<tr>
<th>Month</th>
<th>Total Calls</th>
<th>Total Charged</th>
<th>% Charged</th>
<th>&lt;5min</th>
<th>5-10 min</th>
<th>11-20 min</th>
<th>&gt;20 min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>879</td>
<td>33</td>
<td>3.8%</td>
<td>813</td>
<td>61</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Feb</td>
<td>863</td>
<td>61</td>
<td>7.1%</td>
<td>813</td>
<td>54</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>March</td>
<td>717</td>
<td>76</td>
<td>10.6%</td>
<td>634</td>
<td>80</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>April</td>
<td>740</td>
<td>90</td>
<td>12.2%</td>
<td>636</td>
<td>96</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>May</td>
<td>713</td>
<td>49</td>
<td>6.9%</td>
<td>651</td>
<td>58</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>June</td>
<td>633</td>
<td>58</td>
<td>9.2%</td>
<td>560</td>
<td>56</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4,545</td>
<td>367</td>
<td>8.1%</td>
<td>4,107</td>
<td>405</td>
<td>17</td>
<td>1</td>
</tr>
</tbody>
</table>

Not all calls charged by MD, were posted
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjunctivitis</td>
<td>69</td>
</tr>
<tr>
<td>ADD, Behavior, School Prob</td>
<td>27</td>
</tr>
<tr>
<td>Allergies</td>
<td>16</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>15</td>
</tr>
<tr>
<td>Constipation / Encopresis</td>
<td>7</td>
</tr>
<tr>
<td>Injury</td>
<td>7</td>
</tr>
<tr>
<td>Vomiting</td>
<td>7</td>
</tr>
<tr>
<td>Otitis Media</td>
<td>6</td>
</tr>
<tr>
<td>Depression</td>
<td>5</td>
</tr>
<tr>
<td>Rash</td>
<td>5</td>
</tr>
<tr>
<td>Thrush</td>
<td>5</td>
</tr>
<tr>
<td>Travel Medicine</td>
<td>5</td>
</tr>
<tr>
<td>Asthma</td>
<td>4</td>
</tr>
<tr>
<td>Diaper Rash</td>
<td>4</td>
</tr>
<tr>
<td>Dysfunctional Uterine Bleeding</td>
<td>4</td>
</tr>
<tr>
<td>Strep Pharyngitis</td>
<td>4</td>
</tr>
<tr>
<td>URI/Cough</td>
<td>4</td>
</tr>
<tr>
<td>Anxiety</td>
<td>3</td>
</tr>
<tr>
<td>Feeding Problems</td>
<td>3</td>
</tr>
<tr>
<td>Pinworms</td>
<td>3</td>
</tr>
<tr>
<td>Acne</td>
<td>2</td>
</tr>
<tr>
<td>Back Pain</td>
<td>2</td>
</tr>
<tr>
<td>Birth Control</td>
<td>2</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>2</td>
</tr>
<tr>
<td>GERD</td>
<td>2</td>
</tr>
<tr>
<td>Impetigo</td>
<td>2</td>
</tr>
<tr>
<td>Injury</td>
<td>2</td>
</tr>
<tr>
<td>Insomnia</td>
<td>2</td>
</tr>
<tr>
<td>Pharyngitis</td>
<td>2</td>
</tr>
<tr>
<td>Vaginal Candidiasis</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
</tr>
</tbody>
</table>
# Jan-June Charged Calls

<table>
<thead>
<tr>
<th>Code</th>
<th>Total Charges</th>
<th>Total Paid</th>
<th>Total Adjusted</th>
<th>Total AR (Due)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>$</td>
<td>#</td>
<td>$</td>
</tr>
<tr>
<td>99441</td>
<td>306</td>
<td>$4,380.00</td>
<td>186</td>
<td>$2,488.20</td>
</tr>
<tr>
<td>99442</td>
<td>16</td>
<td>$320.00</td>
<td>13</td>
<td>$257.13</td>
</tr>
<tr>
<td>99443</td>
<td>1</td>
<td>$20.00</td>
<td>1</td>
<td>$20.00</td>
</tr>
<tr>
<td>TOTAL</td>
<td>323</td>
<td>$4,720.00</td>
<td>200</td>
<td>$2,765.33</td>
</tr>
</tbody>
</table>

Avg Payment $13.83
# Who Paid

<table>
<thead>
<tr>
<th></th>
<th>#</th>
<th>$</th>
<th>%$</th>
<th>Avg $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guarantor</td>
<td>172</td>
<td>$2,266.23</td>
<td>91.1%</td>
<td>$13.18</td>
</tr>
<tr>
<td>Insurance</td>
<td>14</td>
<td>$221.97</td>
<td>8.9%</td>
<td>$15.86</td>
</tr>
</tbody>
</table>

**Medicaid Managed Care** 8  
**Anthem** 4  
**Aetna** 2  
**PHCS** 1  
**United HealthCare** 1
Practice Experience Summary

- First six months
- Revenue of $2,765.33, annual ~$6,000 or over $1,000 per MD
- Change in documentation = better documentation
- Additional Expense = Minimal
- Complaints = 2
- Patients who left the practice = 0
Part IV

Making the Business Case for Telephone Care Payment
TOP 10 Reasons to Provide Telephone Care

Telephone Care has been proven to

1. Reduce costs for chronic care
2. Reduce referrals to UCC and ED
3. Reduce unnecessary office visits
4. Increase compliance and patient satisfaction
5. Be effective in patient education and training
6. Improve adherence to treatment protocols
7. Be an integral part of case management and enhance the “Medical Home,” prevent fragmentation of care
8. Improve accessibility to PCP services
9. Give consumers more options
10. Increase patient satisfaction with PCP, health plans
Section on Telehealth Care (SOTC)

- Provides the best CME on quality telehealth care for pediatricians and nurses
- Advocates for payment for non-face-to-face services provided to pediatric patients
- Promotes the use of telehealth care to protect and advance the pediatric medical home
- Affiliate membership for nurses and administrators involved with telehealth care
- SOTC wants you to be a member at www.aap.org/sections/telecare