



Payment for Telephone Care

Section on Telephone Care and Committee on Child Health Financing

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

ABSTRACT

Telephone care in pediatrics requires medical judgment, is associated with practice expense and medical liability risk, and can often substitute for more costly face-to-face care. Despite this, physicians are infrequently paid by patients or third-party payors for medical services provided by telephone. As the costs of maintaining a practice continue to increase, pediatricians are increasingly seeking payment for the time and work involved in telephone care. This statement reviews the role of telephone care in pediatric practice, the current state of payment for telephone care, and the practical issues associated with charging for telephone care services, a service traditionally provided gratis to patients and families. Specific recommendations are presented for appropriate documenting, reporting, and billing for telephone care services.

BACKGROUND

Telephone care is an increasing component of pediatric practice. Pediatricians are forced to provide more care to children and their families by telephone because of changing consumer and health plan expectations for enhanced access to care, 2-parent employment, the use of cellular phones by a “connected” society, a new focus on chronic disease management, and continued pressure by employers and health plans to reduce the costs of medical services. To address these concerns, pediatricians are required to develop new practice styles and provide more “non-face-to-face” medical services outside the traditional office or hospital setting.

Expansion of telephone care has great potential to further decrease health care costs, in part by providing a convenient and safe alternative to more costly in-person services. As a cost-containment strategy, telephone triage and advice, combined with indicated prescriptive therapy, often serves as a substitute for a patient visit to the office, urgent care center, or emergency department (ED). Tools to improve triage, provide advice for acute illnesses, and improve clinical and functional outcomes for the chronically ill patient include guidelines, disease and case management, and patient education. Many of these interventions depend heavily on the telephone.

Despite the fact that telephone care involves challenging medical decision-making, medicolegal risk, and practice expense and provides convenience and cost benefits to patients and health plans, physicians are rarely paid for providing telephone care. Arguments against payment have included the difficulty in determining appropriate payment without a more exact assessment of physician work than that contained in the *Current Procedural Terminology* (CPT) telephone codes, the absence of time-based codes as a proxy for work, and the absence of Centers for Medicare and Medicaid Services–published resource-based relative value units (RVUs) for these services. Additional barriers to payment for telephone

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Key Words

telephone care, payment, telephone triage, after-hours call centers, non-face-to-face services

Abbreviations

ED—emergency department
CPT—*Current Procedural Terminology*
RVU—relative value unit
AAP—American Academy of Pediatrics
E/M—evaluation and management
AHC—after-hours call center

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care include educational gaps in telephone management, perceived ethical concerns in billing families for services traditionally provided free of charge, and practical concerns for documentation and billing for services.

Recognizing the growing importance of telephone care in today's physician practices and acknowledging the significant barrier posed by the lack of a consistent and rational system for payment of these services, the American Academy of Pediatrics (AAP) has developed this policy statement, which will review the role of telephone care in pediatric practice, summarize the evidence for clinical effectiveness of telephone care, review the current state of telephone care payment, and discuss practical considerations for pediatricians seeking payment for telephone care. Finally, this statement presents recommendations for determining which telephone care services delivered by physicians should be considered separate and distinct from the preservice or postservice work of evaluation and management (E/M) services. For physicians who elect to charge for telephone care, suggestions for practical implementation are provided. These suggestions include office procedures, communication with families, and documentation and reporting of telephone codes.

TELEPHONE CARE IN PEDIATRIC PRACTICE

The first recorded use of the telephone in pediatric practice was reported in *The Lancet* in 1879, describing the evaluation of an infant with croup using the newly developed telephone. By 1968, a practice survey reported that pediatricians spent up to 30% of their work day on the telephone,¹ and in 1981, practice surveys reported that pediatricians spent more time on telephone care than did physicians in other specialties.² The increasing burden of telephone care in pediatric practice was reflected in a 1987 survey in which pediatricians reported that telephone care was the least satisfying part of their practice. In 1993, the first pediatric after-hours call center (AHC) opened in Denver.³ By 1999, more than 35 children's hospitals had opened call centers,⁴ and some estimates indicate that 25% of all after-hours calls to pediatric offices are handled by call centers.

Practice surveys have reported that telephone care by physicians and nurses accounts for at least 20% of all clinical care in a general pediatric practice and as much as 80% of after-hours pediatric care.^{1,5-7} A study of Colorado- and Utah-based office pediatric practices showed that an average of 2500 calls were managed during office hours and an additional 1000 calls were managed after hours per pediatrician per year.^{8,9} Twenty-seven percent of all decisions by pediatricians to have a patient seen by a specialist are made during a telephone encounter rather than a face-to-face encounter.¹⁰ Telephone care, including standardized protocols, has become a key tool in the management of children with special needs and

those with chronic diseases such as diabetes.^{11,12} Many pediatric medical subspecialists caring for children with chronic and special needs, such as asthma or attention-deficit/hyperactivity disorder, provide significant amounts of telephone-based disease management. It has been suggested that in a busy pediatric neurology practice, more care is provided during telephone encounters than during face-to-face encounters.¹³

Although the practice expenses associated with pediatric telephone care have not been widely studied, a 1999 study showed that the average cost per call at children's hospital-sponsored telephone triage programs was \$12.50.⁴ One study of Colorado office practices estimated the cost of in-office telephone triage to be \$6750 per physician per year.⁹

Telephone care not only is costly but also exposes the physician to increased medical liability risks.¹⁴ This is especially true for after-hours telephone calls, during which the patient's medical history may not be available, a physical examination cannot be performed, nonverbal communication is challenged by the lack of face-to-face contact, and documentation of the telephone calls is often less than optimal. Telephone care is especially risky for pediatricians compared with other specialists. In an analysis of closed malpractice claims from 1985 to 2004, the AAP Committee on Medical Liability found that pediatricians were more likely to have paid claims for telephone care compared with other specialists, and the average payment per claim was also higher for telephone claims than for other claims (\$281 300 [pediatric telephone claims] vs \$254 100 [all pediatric claims]).^{15,16}

CLINICAL EFFECTIVENESS OF TELEPHONE CARE

Telephone care in pediatric practice currently includes triage and advice, disease and case management, medication adjustments, acute illness care, test result interpretation, counseling, and education. Telephone care has been used for follow-up after ED visits¹⁷ and was shown to decrease missed appointments, increase compliance with instruction, and ensure appropriateness of follow-up care.^{18,19} In the area of chronic illness, telephone care has been shown to reduce medical costs, hospitalization, and ED visits for children with diabetes.^{11,20} In a randomized trial of a self-directed parent training program for those with oppositional preschoolers that included weekly telephone encounters as part of a parenting program, investigators found reduced behavior problems in the children, and parents reported lower levels of anxiety, depression, and stress compared with parents in a control group.²¹

Perhaps the best evidence available describing the outcomes of telephone care is in the area of AHCs using standardized algorithms and nurses to deliver telephone care. Studies of telephone care provided in this setting have shown a high rate of parental satisfaction with AHC care^{3,22} and compliance with urgent and home care dis-

position.²³ Disposition decisions made through AHCs using standard telephone triage protocols are also relatively accurate, with reported rates of hospitalization within 24 hours for calls with nonurgent disposition of approximately 1.5 per 1000 calls.²⁴ Although referral rates for urgent care using telephone triage protocols is approximately 20%,^{24,25} this referral rate can be decreased by 50% with the use of second-level physician triage, a process whereby a physician is consulted to review triage dispositions made by call center nurses that include referring a patient for urgent or emergency care.²⁶

PAYMENT FOR TELEPHONE CARE

The American Medical Association's CPT manual, the standard reference for coding medical encounters with patients, categorizes telephone calls under case management services.²⁷ Telephone calls by physicians for case management, including counseling, medical management, and coordination of care, are categorized by complexity of medical decision-making. Case management telephone calls involving simple, intermediate, or complex decision-making are described by CPT codes 99371, 99372, and 99373, respectively. Telephone calls are also included within care plan oversight services codes, which reflect physician work in the complex and often multidisciplinary management of patients being cared for by a home health agency, hospice, or nursing facility. Recent changes in these codes will make them applicable for children managed at home without home health care agencies (ie, by parents or relatives). These services, which can be reported using CPT codes 99374, 99375, and 99377 through 99380, are cumulative over a 30-day period and are reported according to total physician time spent with these activities. Although telephone time is included in these codes, the services provided are much broader. Reporting these charges requires that a physician document the encounter and the complexity (telephone codes) or time (care plan oversight) and submit the charge on a CMS-1500 form. Physicians must be prepared to collect a patient's copay if required by the insurance carrier. Furthermore, if the insurance carrier allows the charge but deems it an uncovered service, the physician must then bill the patient directly for the service.

Physician experience with payment for telephone care is limited, because government payors and most private health plans do not pay physicians for these services even when available CPT codes are used.²⁸ Certain Medicare plans pay for telephone calls during which care plans are organized or reviewed. Although most Medicaid programs do not reimburse providers for telephone care, some Medicaid managed care plans include telephone triage as one of their covered services under capitation. A study of payment for telephone codes (99371–99373) at a clinic in Texas for care provided by

physicians or nurses for children with diabetes showed that Texas Medicaid did not reimburse for telephone management of complex problems, but 14 of 18 insurance companies reimbursed at 26% of charges, and parents paid copays at 54%.¹² In that study, the authors reported that the collection rate for telephone care for patients with diabetes in a largely insured population was 33%.

Practice surveys indicate that payment for telephone care is supported by most pediatricians.²⁹ Pediatricians convincingly argue that the physician work component of telephone care shares all the characteristics of in-office care except for the hands-on physical examination. They also cite the increased liability risks and practice expenses³⁰ of telephone care as a justification for payment and note that the increased documentation required for telephone care compensation would actually decrease the liability of telephone calls and increase patient continuity of care. Additional arguments for payment of specific telephone encounters include benefits to patients, physicians, and third-party payors, because telephone care is cost-effective compared with traditional face-to-face encounters in the office or ED.³¹

Among pediatricians, there is evidence of increasing advocacy for payment for telephone care. In its statement titled "Principles of Child Health Financing,"³² the AAP defined a set of principles of child health care financing and concluded that such financing should encourage the delivery of services in the most timely, medically appropriate, and cost-effective setting, including appropriate payment for medical care provided via telephone. In addition, the AAP statement acknowledged that all chronically ill children have special needs that require appropriate health care financing for E/M, care coordination and case management, team meetings and conferences, and delivery of medical and surgical subspecialty care. The AAP also recently developed a white paper titled "Reimbursing Physicians for Non-Face-to-Face Care," which supported payment for non-face-to-face care in preparation for the development of a new set of CPT codes and corresponding RVUs for telephone care and Internet medical services.³³

Support for payment for telephone care is not limited to pediatricians. In a recent policy statement, the American College of Physicians³⁴ also endorsed payment for telephone care, stating that it supports "payment by Medicare and other payors for health-related communications, consultations, and other appropriate services by telephone."

PRACTICAL CONCERNS WITH SEEKING TELEPHONE CARE PAYMENT

Although support for payment for telephone care is widespread, some physicians, reluctant to charge for telephone care, have raised ethical concerns that billing

for telephone care may create a barrier to health care access and deter poor families from calling with serious problems. Of course, this concern was also true with patient copayments, a practice that no longer generates either ethical or access concerns in most offices. The issue of access to telephone care reflects the broader societal nature of the problems of access to care and the inequities that exist within our current health care system.³⁵ In a market-driven health care system such as that found in the United States, it is difficult to make the case that physicians should provide clinical care without payment, and as such, the AAP believes that there are no ethical conflicts in charging for telephone-care services rendered. The problem of access to care by telephone should not be laid before physicians but put before citizens and policy makers, and the AAP believes it is appropriate for pediatricians to advocate for more comprehensive coverage.

Another concern that has been raised regarding payment for telephone care is that this practice will increase the overall financial burden placed on the nation's health care industry. In response, others argue that an even greater risk is that, without compensation for telephone encounters, medical practices already facing increasing financial and productivity pressures may be unable to provide telephone care and instead may require patients to come in for face-to-face visits to either the office or the ED to address medical concerns that could be managed readily over the telephone. This will result in patient access limitations, unwarranted ED use, decreased chronic care and disease management, increased expenses to patients and third-party payors, and an overall increased burden on the health care industry.

Given that the current payment system encourages the provision of care in an office setting, it is expected that increases in costs for telephone care will be more than offset by the savings incurred when physicians begin to provide more efficient telephone care for certain illnesses and chronic diseases rather than requiring patients to be seen in a more expensive face-to-face encounter. From the perspectives of both the patient facing copayments or an increasing portion of out-of-pocket expenses and the insurance companies paying for costly emergency and office visits, telephone care makes economic sense. As consumer-driven health plans become more commonplace, demand for telephone care will likely grow as consumers seek more cost-effective and convenient care choices.

Other concerns with charging for telephone care include the risk that this practice might create a negative physician image or allow for overuse or fraudulent billing for these services. With trends among consumers of increased expectations for services on de-

mand at the time and place of the customer's choosing, it can be argued that the responsiveness of physicians will increase, rather than decrease, consumer satisfaction and improve physician image. Physicians often fear that the introduction of fees for selected medical services, such as telephone care, or office services, such as form completion, will alienate patients and cause them to leave their practice. Yet, anecdotal reports suggest that many of these fees have become commonplace in offices across the country without patient exodus. Regarding concerns that physicians charging for telephone care may be tempted to overuse and/or abuse charges, no evidence has been uncovered that the ability to charge for telephone care, especially if codes with clear reporting criteria were used, would create any new or unique opportunities for physician fraud or abuse.

RECOMMENDATIONS

1. The AAP supports reimbursement by payors, including state Medicaid agencies, for telephone care services provided by physicians to established patients, including the following categories of medical services:
 - calls for physician management of a new problem, including counseling, medical management, and coordination of care not resulting in an office visit within 24 hours;
 - calls for physician management about an existing problem for which the patient was not seen in a face-to-face encounter in the previous 7 days; and
 - calls related to care plan oversight for patients with special needs in residential settings and/or those with a chronic disease who require physician supervision over a period of time during a calendar month.
2. The AAP believes that pediatricians should make efforts to negotiate fee schedules and/or capitated rates for telephone care payment with all payors including state Medicaid agencies. When necessary and appropriate, physicians are encouraged to track utilization of telephone care codes and to appeal insurance denials.
3. Within the terms of existing payor contracts, the AAP supports pediatricians charging families for telephone care. The AAP also supports the exploration by pediatricians of different charge structures for telephone care, such as "per-call" rates or prepaid monthly telephone "access fees" that may help families anticipate telephone care expenses. Pediatricians choosing to charge patients and families for telephone care should ensure that they do the following:

- Develop office policies and procedures to ensure consistent processes for reporting telephone care charges to third-party payors and collecting payment for uncovered but allowable telephone care services while maintaining compliance with the Health Insurance Portability and Accountability Act (HIPAA) (Pub L No. 104-191 [1996]).
 - Develop a clear communication plan for patients before initiating a fee for telephone care. Patients should be informed about the types of calls that will be billed and should be instructed that a copay (or possibly the entire charge) may be their responsibility if their insurance company does not cover telephone care service. Patients should be instructed that if they choose not to use care provided by telephone, standard office-based care will remain available, and they will always have the choice to have a face-to-face encounter if they so choose.
4. The AAP believes that physicians should document telephone care in a consistent manner.
- Documentation should fulfill the need for continuity of care, demonstrate the complexity of the call, and meet the requirements of the typical E/M visit. Suggested items to document include the date and time of the call, patient's name and date of birth, name of caller, reason for the call, total encounter time, relevant patient history and evaluation, assessment of the issue at hand, plan, and disposition of the call.
 - It is suggested that the physician document the type of telephone encounter (eg, new problem, review of chronic problem with change in management, interpretation of test results, coordination of care, etc) to demonstrate the expertise required and the complexity of the decision-making process. Documentation for all telephone encounters for which a patient is charged should be placed in the medical record.
5. The AAP supports the development of mechanisms for payment for telephone care services provided by pediatric providers, including triage and advice, care coordination, patient education, and chronic disease management, and will provide support, along with other professional societies, for efforts to develop a new set of CPT codes with assigned RVU values for non-face-to-face medical services including telephone care.
6. The AAP believes that additional research should be undertaken to evaluate and report the clinical and economic effects of seeking payment for telephone care on patient access to care, quality of care and outcomes, total health care expenditures, and patient and physician satisfaction.

SECTION ON TELEPHONE CARE, 2005–2006

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