Optometry Coding & Billing Alert

Avoid Writing Off Every Physician Phone Call

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Almost every physician has to call another physician or medical professional to discuss a patient. Your challenge is finding out how to collect for that time spent on the phone. Can you actually get paid for that time on the phone?

While CPT offers three codes for telephone services, don't expect to get paid when you submit them. Only an occasional payer will pay for the calls. The codes are:

- 99371 -- Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other healthcare professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief

- 99372 -- - intermediate

- 99373 -- - complex or lengthy.

Most insurance payers consider these types of telephone calls part of your physician's business tasks, and therefore will not reimburse anything for them. Medicare has never paid on these codes, and there are no published relative value units for 99371-99373.

-This is due to there being no direct -face-to-face- contact between the physician and the patient,- says **Kimberle R. Greuel, RHIT, CPC,** reimbursement analyst lead for MeritCare Health System in Fargo, N.D.

-The physician has already developed a relationship with patients and will from time to time need to discuss issues with them by telephone, whether it is giving them lab results, questions on medications, etc. It is understood from the payer perspective this is just part of good patient care,- she says.

Tip: Occasionally, some private payers will pay on these codes, so you can try reporting them and see if the payer pays you. For example, some Blue Cross/Blue Shield plans are paying for after-hours calls. For instance, Blue Cross/Blue Shield of California pays $18 for a level-two call (99372).

Caution: Consider the public-relations aspect of a denied claim before you submit telephone charges to a payer. -If you bill the service to an insurer that doesn't cover the service, the bill could drop to the patient, which is a PR nightmare,- says **Carol Pohlig, BSN, RN, CPC,** senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia.

If the payer doesn't pay the claim, experts recommend that you write it off to a special category of -phone calls not paid- and don't bill it to the patient. Keep track of the write-off information and use that information to negotiate with your payer later on. This is especially helpful for rural communities in which patients don't necessarily come into the office.

Count Calls Toward MDM When Possible

Just because your payer doesn't recognize codes 99371-99373 doesn't mean that time isn't reimbursable. The most widely recommended option is to apply the time and effort spent on the telephone call when deciding the appropriate level of E/M service for the patient's next visit with the doctor.

While phone time won't increase the level of E/M service, phone calls, especially consultations with other physicians, can help to boost the level of medical decision-making (MDM) for the patient's next visit.

Pointer: If you choose to apply the time to the medical decision-making, be sure your physician properly documents the phone conversation in the office note, wrapping it into the next visit.

-Telephone calls are inclusive in the payment for the E/M pre- or post-service work,- Pohlig says. -If documented appropriately, you can receive credit in the amount and complexity of data in MDM.-

Beware: Phone calls should usually be bundled into the E/M visit without affecting the level of service. Look for specific signs that a phone call was significant and should count toward the next E/M visit. These include:

- the decision for more treatment after the phone call

- a prescription (or even a refill) or a dosage change over the phone

- discussion of new symptoms

- the decision that a condition is worsening, or a new condition has been added

- informative chats with family members and previous providers.

Any of those factors would increase the complexity of medical decision-making at the next visit when wrapped into the context of that visit's MDM.