Part B Insider (Multispecialty) Coding Alert

EVALUATION & MANAGEMENT: Make Your Phone A 'Hot Line' For E/M Reimbursement

Carrier says physicians' phone time can bump up E/M levels

Does your physician spend precious minutes on the phone with patients or caregivers, instead of seeing patients? That time can still increase your reimbursement, if it's documented properly.

Good news: "A physician cannot bill for phone calls, but the services he provided could be incorporated into the level of complexity of the next E/M service," says Part B carrier Noridian Administrative Services in a recent "Frequently Asked Questions" file on its Web site.

In other words, "if the physician has communicated medical decision making (MDM) information to the patient over the phone prior to the next E/M service, and reviews this information during the patient visit, it counts as MDM data," says **Cindy Parman**, a consultant with **Coding Strategies** in Powder Springs, GA.

But you can't use phone time to increase the amount of time for counseling and coordination of care, which is based on face-to-face time, Noridian cautions.

Beware: This is a gray area, and phone calls don't always have the same impact on your E/M levels, warns **Marcella Bucknam,** coding manager for the **University of Washington's** physician group in Seattle. Don't let your physician get the idea that every phone call should boost E/M reimbursement.

The Relative Value Units (RVUs) for E/M codes include work before and after the visit, including "reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact," according to the CPT manual. So phone calls usually should be bundled into the E/M visit without affecting the level of service, says **Quinten Buechner**, a consultant with **ProActive Consulting** in Cumberland, WI.

Signs: But you should look for specific signs that a phone call was significant and should count toward the next E/M visit, says Bucknam. 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; and

• informative chats with family members and previous providers.

Any of those factors would increase the complexity of medical decision making at the next visit.

Example: An existing patient with chronic obstructive pulmonary disease calls in with complaints of increasing shortness of breath. The doctor finds out that the patient hasn't been following his treatment regimen, and warns the patient about ongoing compliance. The doctor tells the patient to take his current medication, explains which symptoms might require

the patient to go to the Emergency Room, and schedules a visit in a couple of days. When the patient comes in, he appears to be stable, and the doctor schedules another visit two months later.

Normally, a visit where the patient appears to be stable would merit the lowest level of decision making, says Bucknam. But if the doctor documented that phone call, including the new problem of the patient's non-compliance with medications, then that visit could warrant a much higher level.

The physician should document exactly what she discussed with the patient, to justify the increased E/M level in case of an audit, cautions **George Ward**, billing supervisor with **South of Market Health Care** in San Francisco.