REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-10

Subject: Payment for Electronic Communication (Resolutions 111, A-09, and 809, I-09)

Presented by: Barbara L. McAneny, MD, Chair

Referred to: Reference Committee A (Glenn A. Loomis, MD, Chair)

The House of Delegates (HOD) referred Resolutions 111 (A-09), "Payment for Email Consultations by Medicare" and 809 (I-09), "Reimbursement for Professional Services." The Board of Trustees referred these two items to the Council on Medical Service for a report back to the HOD at the 2010 Annual Meeting. Resolution 111 (A-09), introduced by the Michigan Delegation, asks our American Medical Association (AMA) to "work with the federal government and the Centers for Medicare and Medicaid Services (CMS) to provide adequate compensation for email consultations and replies to enhance the patient experience and the speedy delivery of health care." Resolution 809 (I-09), introduced by the Florida Delegation, asks our AMA to "pursue legislation requiring physician reimbursement for time spent providing professional services through the use of such modalities as telephone, email and other electronic communication methods, regardless of the treating physician's physical proximity to the patient at the time those services are rendered."

This report provides background on electronic communication technologies, describes AMA advocacy efforts to compensate physicians for electronic communications with their patients, highlights technological innovations in patient-physician communication, discusses payment solutions and provides recommendations in support of payment to physicians for electronic communication.

BACKGROUND

Innovative information technology has expanded the definition and capabilities of electronic communication. Electronic communication includes email, text messaging and Web-based platforms that allow real-time face-to-face interactions (e.g., Skype). Electronic communications with patients and care providers can be delivered via the Web, mobile devices and Interactive Voice Recognition. Advancements in health information technology include, but are not limited to, electronic health records (EHRs), real-time video for telehealth consultations and diagnosis, remote patient monitoring systems, mobile and other portable report monitoring systems.

The public perceives electronic communication as a means to quickly and conveniently access health care advice and a way to enhance encounters with their physicians. According to the California HealthCare Foundation, 78% of health care consumers want to interact with providers online. A Harris Poll study showed that 56% of people surveyed stated that the ability to communicate with their physician electronically would influence their choice of doctor. A survey of physicians found that 39% of US physicians communicated with patients online in 2009, up from 16% in 2004 (Manhattan Research, 2009). Concerns that technology will lack a mechanism

for payment, compromise patient-physician confidentiality and potentially increase workload are prominent barriers to physicians corresponding with patients electronically. As CMS and private health plans pay providers to use technologies that enhance patient care and improve physician efficiency, the willingness of physicians to address these concerns may increase.

AMA POLICY AND ADVOCACY

The Council on Medical Service previously addressed online and email communications with Council Report 4-A-01, "Medical Care Online," which discussed the benefits and potential drawbacks of online medical care; socioeconomic and cultural obstacles to online communication, patient literacy and differences in computer use among various ages; as well as concerns about Health Insurance Portability and Accountability Act (HIPAA) provisions, privacy and patient-physician confidentiality. The report noted that online medical care may improve quality of care and efficiency and decrease administrative costs. The report recognized challenges to adopting electronic communications including decreased face-to-face care, liability concerns, time constraints, insufficient technical support and concerns about compensation. The physician concerns highlighted in Council Report 4-A-01, as well as the guidelines regarding communication, medical and legal concerns continue to be relevant (Policy H-478.997, AMA Policy Database).

The HOD has adopted several policies to direct advocacy for payment of non face-to-face communication with patients. Policies H-390.859 and H-390.889 state that the AMA will urge CMS and other payers for separate recognition of telephone, fax, electronic mail or other form of communications with established patients. At the 2009 Annual Meeting, the HOD adopted "Joint Principles of the Patient-Centered Medical Home," which state that payment for the medical home should support provision of enhanced communication access such as secure email and telephone consultation (Policy H-160.919).

Consistent with Policy H-480.974[4], the CPT Editorial Panel established CPT code 99444 for the billing of online patient services. The service can be reported only once for the same episode of care in a seven-day period and includes all other communications stemming from the online encounter, including follow-up telephone calls and pharmacy, lab and imaging orders. The AMA/Specialty Society Relative Value Scale Update Committee (RUC) assisted in valuing this service by surveying seven major specialty organizations. The RUC determined that the definition of work and physician time and complexity involved in this service could vary significantly, making it difficult to recommend a specific relative work value, thus the RUC recommended that the work described be priced by payers.

In its guidance regarding CPT Code 99444, CMS noted that Medicare does not pay separately for physician telephone conversations with patients or their families for communications unrelated to an Evaluation and Management (E/M) visit. CMS suggests that physicians determine which level of E/M code to assign on the next claim for a face-to-face E/M visit when consulting patients either by phone or email. Physicians may directly bill the beneficiary for these services as defined by CPT Code 99444, at their established rate. Though CMS does not require an Advanced Beneficiary Notice (ABN), physicians are strongly encouraged to issue a voluntary statement to inform patients that Medicare does not pay for email services. The Council recognizes the challenges of collecting payment for services that are not covered by Medicare and is concerned ABNs do not offer a practical option for physicians to receive payment for email communications with the Medicare population. In 2008, CMS applauded the RUC for submitting work relative value recommendations and direct practice expense inputs for the Medicare Medical Home Demonstration project. The RUC's recommendations emphasized physician work values for

integrated communication and coordination with other physicians and health care professionals and communication with the patient, family and caregivers.

To assist physicians in private practices who wish to communicate with their patients electronically, the AMA Practice Management Center published the document "Online medical consultations: Connecting physicians with patients." This document, available online at: http://www.ama-assn.org/go/pmc, provides guidelines for physician use in integrating online portals into their practice and recommends strategies to receive payment for online communications.

ELECTRONIC COMMUNICATION TOOLS

An increasing number of patients and their employers have shown a greater interest in utilizing messaging tools to increase efficiency and enhance communication with health providers. The private sector has taken a leadership role in developing the various electronic communication tools that are described in this section, including unencrypted Internet-based email, encrypted Internet-based email, Internet portals that enable secure messaging, online consultations, virtual office visits and e-consultations. Many insurers recognize that technology can be used to control costs and are offering incentives for patients and physicians to use the efficiency and convenience of electronic communication. In 2010, UnitedHealthcare released its policy for the payment of medical services delivered other than in-person (e.g., over the phone, Internet, or using other electronic communication devices). UnitedHealthcare will pay for telehealth services that occur via interactive audio and video telecommunication systems.

Unencrypted and Encrypted Internet-Based Email

Unencrypted Internet-based email (e.g., Google mail, Yahoo! and Microsoft Outlook) is a low-cost, easy to use, readily available medium that allows communication between patients with email accounts and the physician practice. Email communication offers health providers the opportunity to clarify medical advice and document information and instructions that would be useful for patients (e.g., addresses, phone numbers for facilities where patients are referred, test results with interpretation and advice, links to sites for additional patient education and instructions regarding medication). However, unencrypted email does not provide the necessary security for transmitting sensitive and private health information, the format to quickly read and respond to the patient, the capacity to indicate the level of urgency or level of clinical complexity. Nor does the format provide a mechanism to bill patients for the interaction. Also, unencrypted email can be forwarded, manipulated or taken out of context without the consent or knowledge of the provider.

Recent updates to HIPAA introduce significant new consequences for health information technology security breaches. Though more cumbersome, encrypted email provides additional ways for patients and physicians to correspond and meet new HIPAA security standards. Encrypted email requires patients to access a secure messaging Web site where the communication subject is structured (e.g., prescription refills, appoint requests, or clinical questions). The secure messaging application notifies patients via their unsecured email account to retrieve provider responses from the encrypted Web site. In January 2010, Prime Healthcare Services, a California-based regional health system, contracted with the Zix Corporation to provide its "Email Encryption Service," a simple email encryption solution for physicians and patients. Physicians or health systems accessing encryption services pay an annual fee to participate and patients either submit claims to their insurance or pay their providers directly.

Online Consultations/Virtual Office Visits/E-consultations

Online consultations, virtual office visits and e-consultations are structured telehealth communications whereby an established patient presents new symptoms to his or her own physician and the physician diagnoses and treats the patient via the online system. The patient submits answers to questions that the patient's physician reviews to determine if the problem can be handled online, or if the patient should come in for a face-to-face visit. If the visit is appropriate for online treatment, the physician will send the patient a secure message with any treatment instructions, self-care information and necessary prescriptions. Messages are stored on secured servers and they cannot be read, forwarded, deleted, copied or altered in any manner. For example, RelayHealth has a list of about 150 illnesses, including acne and sinus pain, which are considered appropriate for "e-visits." Health insurers including Aetna and CIGNA HealthCare contract with RelayHealth to pay for online physician visits, and patients contribute a copayment for visits.

Internet Portals

Advanced Web-based technologies are developing swiftly to connect patients with clinical health care providers, providers with other providers and providers with business entities. The AMA is working to develop an electronic portal to provide physicians with a single access point to electronic applications that will not only address clinical needs and provide health care information, but will also link to resources to address the day-to-day business concerns of medical practices and ease adoption of health information technology.

Internet portals allow providers to access a single Web site to review patient clinical information, speak with and see patients, prescribe medications as needed and suggest follow-up care. The patient can also request appointments, request lab results, request medication refills and even consult with their physician online with a virtual office visit for certain medical conditions. When encounters are complete, some portals have options for patients to share full records of the visit with their primary care doctor. These systems often connect with health data repositories (e.g., Microsoft's HealthVault™ and Google's GoogleHealth™) that allow patients to maintain their personal health information online, including data from biometric devices (e.g., glucometers, scales or blood pressure monitors) and have the ability to share the health record with providers during live encounters.

Specific examples of a portal system include My HealtheVet, the Veterans Health Administration's portal, which provides veterans with a place to keep track of health information. Additionally, it links to Federal and VA benefits and resources, provides a space for personal health journaling and allows for patients to refill their VA prescriptions. MedFusion, another example of a portal system, provides secure patient messaging and other services such as prescription renewals, patient-initiated secure messaging, personal health records, symptom assessments, virtual office visits and referral management.

The Council notes an additional public health benefit to electronic communication through Web based portals has emerged in recent years with the onset of contagious and severe influenza outbreaks. Last year, the AMA launched the Web site AMAFluHelp.org in response to the H1N1 pandemic. The beta-tested Web site provided a platform for patients and their physician to use evidence-based, patient self-assessment tools to address their H1N1 related concerns. The State of Colorado endorsed the system as a public health intervention.

RESOLUTIONS 111 (A-09) AND 809 (I-09)

Resolution 111 (A-09) is concerned that electronic communication will place additional demands on physician time and resources, particularly if patients attempt to substitute office visits for the convenience of free email exchanges. Consistent with the concerns addressed in Resolution 111 (A-09), AMA policy strongly encourages CMS to compensate for email communications (Policy H-390.859). During testimony on Resolution 111 (A-09), delegates questioned how payment would work using the medical home model for online communications. The medical home model focuses on valuing patient-centered care management work outside of the face-to-face patient visit. Several long-standing AMA policies support physician payment for non-face-to-face encounters (Policies H-385.951 and H-390.889), and the medical home model is designed to offer explicit incentives for enhanced communication access such as secure e-mail and telephone care coordination activities (Policy H-160.919). Although CMS has clearly stated that it will not cover email and phone communications, CMS acknowledged that email communications would be payable under the medical home model because they facilitate care coordination services.

Resolution 809 (I-09) calls for legislative action to reimburse professional health services provided using modalities such as telephone and email. In June 2008, H.R. 6380 was introduced to amend the Social Security Act to provide payments under the Medicare program for unscheduled physician telephone consultation services. The decision to pay physicians for telephone communications would be made based on the outcome of a two-year demonstration project exploring cost and quality. At the time this report was written, the bill has not progressed.

DISCUSSION

The Council recognizes that efforts to receive payment from CMS for email communications have not succeeded for various reasons, including that such a request would likely require a budget neutral reduction in other Medicare services. As noted above, Medicare does not pay for CPT Code 99444, which describes such services, or any communications pertaining to online encounters with patients because it considers such service bundled with other consultation services and thus not separately payable. Medicare states that physicians using the Medicare ABN form can proceed to charge the physician's set rate for communicating via email. However, the Council considers placing the onus of payment for care coordination and consultation services on Medicare patients as ineffective. Until payment models are structured to address electronic communications, the Council continues to support Policy H-390.859[1], which urges payment to physicians for professional services rendered to their patients, regardless of the technology used to deliver the service. The Council recommends modifying Policy H-390.859 [2] to simply state that CMS and other payers should separately recognize and adequately pay for non face-to-face electronic visits.

The AMA, through its work with the RUC, has successfully collaborated with CMS to develop bundled care coordination payments for the Medicare medical home. The Council supports inclusive payments for technology-based care coordination methods, which are more likely to provide an incentive for physicians caring for Medicare patients to use technology without increasing overall workload and cost. In addition, the Council believes that similar payment methodologies for online patient-physician communication could be incorporated in disease management models. Particularly as new technologies emerge, the Council encourages national medical specialty societies to work with CPT and the RUC to continue to methodically develop payment mechanisms for new CPT codes and revise existing CPT codes to address technology-enhanced patient-physician communication.

As called for by the sponsor of Resolution 809 (I-09), the Council considered AMA support of legislation. In contrast to a budget neutral request for CMS to pay for electronic communication, legislation would likely involve a request for new money for the Medicare program. The Council questioned whether it would be politically feasible to lobby for congressional action for additional Medicare funding, given the broader concern of Medicare payment reform. In addition, recent legislative action to pay physicians for telephone communications has stalled as legislators address comprehensive health care reform. For these reasons, the Council believes that regulatory and private sector solutions for patient-physician communication are likely to be more viable.

Secure, encrypted and HIPAA-compliant communication through Web-based portals appears to be an emerging and efficient option for patients and physicians. Insurers are developing ways to pay physicians for their use of Web-based portals, which may ultimately result in better health outcomes. The Council believes that pilot projects would be helpful in targeting innovative payment models for the use of non face-to-face technologies such as Web-portals, "virtual" office visits, and email and telephone communications.

Integrated portal systems require physicians to make a significant investment in the technology, which could hamper progress. The American Recovery and Reinvestment Act of 2009 and other incentives through the Medicare and Medicaid programs are set to begin in 2011 and will provide physicians with a maximum incentive up to $44,000 to make investments in technology. The Council believes that the AMA should continue to update its guidance on technology use to help physicians meet the needs of their patients and practices.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolutions 111 (A-09) and 809 (I-09), and that the remainder of the report be filed:

1. That our American Medical Association amend Policy H-390.859 by addition and deletion to read as follows: (1) The policy of our AMA is that physicians should uniformly be compensated for their professional services, at a fair fee of their choosing, for established patients with whom the physician has had previous face-to-face professional contact, whether the current consultation service is rendered by telephone, fax, electronic mail or other forms of communication. (2) Our AMA presses CMS and other payers to separately recognize and adequately pay for non-face-to-face electronic visits. ~~for separate recognition of such supplemental communication work, not as bundled into existing service codes, or have such services recognized as not covered by Medicare and therefore chargeable as a patient convenience service outside the benefit package of Medicare.~~ (Modify Current HOD Policy)

2. That our AMA advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications. (New HOD Policy)

3. That our AMA continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices. (Directive to Take Action)

4. That our AMA educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians. (Directive to Take Action)

Fiscal Note: Staff costs estimated to be $10,858 to continue updating guidance.
References for this report are available from the AMA Division of Socioeconomic Policy Development.