The Changing Face of Ambulatory Medicine–Reimbursing Physicians for Computer-Based Care

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The Changing Face of Ambulatory Medicine—Reimbursing Physicians for Computer-Based Care

ACP Analysis and Recommendations to Assure Fair Reimbursement for Physician Care Rendered Online

Policy Paper of the American College of Physicians

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I. Executive Summary

The purpose of this paper is to shed light on how the revolution in the way people communicate, by computers over the Internet, is changing the face of how medicine is practiced. Until recently, patients have had only two primary ways of actively communicating with their physicians—through a face-to-face office visit or through the hit-or-miss use of telephones. Yet, there is a wide spectrum of nonurgent patient conditions that could be effectively managed without the time and expense of an office visit, through a carefully structured e-consult system focused on established patients, which gathers all information necessary to render an informed medical decision, with the added benefits of automatically documenting the patient–physician encounter while protecting patient confidentiality. This e-consult approach, within the framework of the established doctor–patient relationship, has many advantages over telephone contact, since physicians cannot always reach callers in timely fashion, while patients may not provide all the information needed to render a medical decision.

Surveys cited in this paper show that both physicians and the public alike are using computers and the Internet more and more every day and that the major barrier to physicians using e-mail consultations to provide care to their established patients is the lack of reimbursement for this service by Medicare and many private payers. Some private sector health insurers have displayed great initiative in bringing this technology to their enrollees, with recent pilots of the "webVisit" by organizations, such as Blue Shield of California, Aetna, and ConnectiCare, showing outstanding results, saving nearly $2 per member per month, accompanied by a high level of physician and patient satisfaction. The program has been so successful that Blue Shield of California recently announced that it will make it available to all of its 2 million members (1, 2).

This paper urges the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare, and other insurers to take note of the great potential that computer oversight of patients can have in terms of conserving and more effectively using precious funds and allowing physicians to better serve their patients, reserving office visits only for those patients who truly need face-to-face care. By paying for e-mail consultations with established patients, all parties will benefit: Physicians can spend more time serving their patients, yielding a happier and healthier patient population, while the government and private insurers save money by averting sometimes costly and unnecessary face-to-face office visits. Suggested examples of reimbursable and nonreimbursable e-mail consultation services are provided in section VII of this paper. Following are ACP's recommendations relating to reimbursement of computer-based physician care of established patients.

Recommendation 1:

ACP supports reimbursement by Medicare and other payers for health-related communication, consultations, and other appropriate services via the Internet, subject to guidelines on the level of work required for the service to be reimbursed as a separate service outside of the usual evaluation and management (E/M) service.

Recommendation 2:

Medicare and other payers should work with the physician community to develop guidelines on reimbursement of health-related communication, consultations, and other appropriate services via the Internet. The guidelines should include examples of both reimbursable and nonreimbursable Internet-related communication.

Recommendation 3:

Payment for health-related Internet communication should not result in a reduction in separate payments for evaluation and management (E/M) services. Such reimbursement should also not be subject to budget-neutrality offsets under the Medicare fee schedule.

II. Introduction

In the world of patient–physician interactions, time is precious—but generally not reimbursable if the doctor and patient are not in the same room, according to outdated Medicare rules. Rapid advances in computer communications technology have made it possible for physicians to provide care to and monitor their patients without the inconvenience and cost of an office visit. Some experts believe that online patient consultations could produce a 20% decrease in office visits (3), saving consumers an estimated $7 billion per year (4). Yet, while patient demand for online contact with their physicians has soared and led several health insurers to pay physicians for such "e-visits," Medicare continues to buck this burgeoning trend, refusing to reimburse non–face-to-face care, except for a few highly limited services (e.g., radiology readings and cardiac and blood pressure monitoring).

Surveys of both patients and physicians show a rapidly expanding interest and use of computer communication technology for medical research, education, and treatment purposes. This revolution in how medical care and information are handled, powered by dramatic growth in use of the Internet, "has the potential to profoundly impact how physicians practice medicine, the quality of medical care patients receive, as well as the patient–physician relationship," according to a June 2001 American Medical Association (AMA) report (5).

Evidence of this growth in computer-based patient–physician communication is plentiful. In November 2001, the California HealthCare Foundation reported that: "More than half of American adults are now using the Internet. . . . As many as 3.7 million Americans are already communicating with their physicians by electronic mail. . . . Web-based technology and the Internet offer new ways for patients and their caregivers to communicate, sometimes avoiding the need for telephone calls, paper communications, or even face-to-face encounters" (6).

As use of computers and electronic exchange of patient medical information become more commonplace, Medicare's system for reimbursing physicians has failed to keep pace, refusing to pay physicians for time spent communicating with and monitoring patients over the Internet. Though use of such communication technology promises better quality of care and more efficient use of physician time, the January 25, 2002 *Wall Street Journal* (7) and a December 2001 physician survey by Deloitte Research and Fulcrum Analytics (8) come to the same stark conclusion: until physicians are duly reimbursed for time spent interacting with and overseeing patients online, the adoption of new communication technology by physicians will be greatly slowed.

Physicians who have used computer-based tools to enhance their practice of medicine have found them "highly effective" and have concluded that "electronic medical records, electronic prescribing, online communication with patients, and remote disease monitoring have significantly boosted their efficiency and the quality of care they provide" (9).

III. Reimbursement for E-Mail Consultations Is Expanding among Private Insurers while Medicare Continues to Resist

While Medicare continues to ignore the benefits of computer-based communication with patients, a vanguard of health care industry leaders is embracing and promoting such electronic interchange with patients, setting a precedent by reimbursing physicians for e-mail consultations. In January 2001, First Health Group Corporation, a preferred provider organization based in Illinois, began paying their physicians $25 for electronic consults, with a maximum of 25 consults per member, per year, based on data showing that increasing contact with physicians helped reduce hospital visits for patients with chronic diseases (10).

In 2001, a number of insurers and employers began pilot testing a Web-based structured physician-consulting system. The webVisit is a "non-urgent, structured clinical communication between a patient and his/her physician. The webVisit moves beyond e-mail or simple messaging to replace an office visit or phone consultation for follow-up. Unlike e-mail, the webVisit is secure, clinically structured and provides a mechanism for physician reimbursement" (11). Physicians are paid a fixed fee for each e-consultation ($20–$25), and patients may pay a nominal copay ($5–$10) (12).

In May 2001, 16 Silicon Valley employers joined together with Blue Shield of California to pilot webVisit for their employees. The goals of the pilot are "improving communication between patients and physicians, reducing employee absenteeism, and ultimately lowering skyrocketing employer health costs" (12). A 20% reduction in the number of face-to-face visits, while being cost-effective or cost-neutral for physician practices, was projected (13). WebVisit is also being piloted in Connecticut, where the program was launched in August 2001, a joint venture of two major HMOs, Aetna and ConnectiCare, Inc., and ProHealth Physicians, the largest primary care physician group practice in the state (14).

In January 2003, a final report on the impact of the webVisit pilots was released by researchers at the University of California, Berkeley, and Stanford University (1). The study's results were impressive: Compared to a control group of patients, those using webVisit showed a $1.92 per patient, per month reduction in spending related to physician office visits, while total health care spending was reduced $3.69 per patient, per month. Surveys of various measures of patient and physician satisfaction were extremely high for those using the webVisit program (1). Based on these findings, Blue Shield of California began paying its HMO and Preferred Provider Organization-contracted physi-

cians for online consultations in the first quarter of 2003, estimating that it could potentially save more than $3 million a month once its 2 million members are eligible for these e-consults (2).

In addition to cost savings, physician users of the webVisit have reported a number of other benefits resulting from online communication with patients, including the following:

1. It saves time relative to communicating with patients by telephone;
2. It provides better documentation and liability protection; and
3. It allows physicians to see more patients because they are able to address needs of patients on the Internet who previously would have called or taken an office appointment slot.

Relative to the latter, Eric Lieberman, MD, Medical Director of the University of California Davis Health System, has stated: "Our data suggest that productivity per day and per visit has statistically gone up significantly. . . . What we're assuming is happening is that low-level Evaluation and Management office visits are being moved to the Web, freeing up that time for higher level office visits" (2). This means that physicians who use webVisit can focus on providing face-to-face care to patients with more complex health care needs that require a visit to the doctor's office.

The revolution in computer communication technology is clearly transforming the way medicine is practiced, but the benefits of these changes are largely being denied to Medicare beneficiaries. At a time when reimbursement problems are undermining Medicare (15), harnessing this technology can help. Face-to-face visits solely for the purpose of rendering explanations or interpretation of tests can be expensive and unnecessary. They take physician time and expertise, both of which are valuable and should be compensated as part of care delivery, but can be accomplished more economically and efficiently via e-consults, which also serve to reserve precious office appointments for more complicated patient health care issues. Utilization of computer communication technology would reduce hassles and wasted time for patients and their physicians and overall would save Medicare money. E-consults cannot be a free service, however, as they involve evaluation and judgment of the physician and the infrastructure to deliver the service.

A number of enlightened private insurers have begun to extend coverage to compensate for e-consult care provided to patients, as they see the benefits of providing this service to their beneficiaries. Organized medicine also believes that the time to compensate physicians for non–face-to-face care has arrived, with the American Medical Association (AMA) House of Delegates broadly calling for paying physicians a "fair fee" for services rendered to established patients, "whether the current consultation service is rendered by telephone, fax, electronic mail, or other forms of communication" (16).

IV. A Closer Look at How Computer-Based Communication Is Changing the Way Ambulatory Medicine is Practiced

For physician and patient alike, the Internet represents a vast source of medical information and a quick and efficient tool for exchanging clinical information. According to one physician survey, 89% of doctors use the Internet, averaging 8 hours per week online, of which an average of 3 hours per week (37.5%) is devoted to medical activities. The latter includes communicating with patients, consulting with colleagues, performing clinical research, and issuing prescriptions (9). While patient demand for online contact with their physicians is strong and growing, physicians have resisted using this technology, the major barrier being lack of reimbursement (7, 9, 17, 18). According to a Harris Interactive Survey, the percentage of physicians using e-mail to communicate with their patients has stagnated at 13% between 1999 and 2001 (19).

Between 1998 and 1999, the average annual number of office visits per person declined a steep 10.1% for all age groups (from 3.100 to 2.785 per person), according to the National Ambulatory Medical Care Survey (NAMCS): 1999 Summary (20). Historical trends would predict that the number of office visits should actually be going up rather than down, since the United States population is aging (21) and NAMCS data shows that office visits steadily increase with age after age 25 years (20). If one applies this increasing office care demand factor to a U.S. population whose median age increased 7.3% (from 32.9 years to 35.3 years between 1990 and 2000, according to the 2000 U.S. Census report) (21), one would predict office visits (per patient) to increase over time—but just the opposite is occurring, in part due to the increasing number of patients getting their care, often for free, electronically. The increase in the number of uninsured patients and other potential factors may also explain the decrease in visits per patient.

Following is an overview of current interest in, and utilization of, online patient–physician communications by the consumer and physician communities.

A. Patient Demand for Online Care Is Strong

As more and more physicians and patients acquire the means to communicate by computer, the desire and willingness to apply this technology to the provision of ambulatory care has gathered substantial momentum. Patient demand for online care is extremely strong, according to a Harris Interactive poll taken in 2000. This poll showed that the following percentages of consumers wanted the following types of medical information online: personalized medical information from their physician following an office visit (80%), electronic health alerts from their physician (84%), charts to monitor chronic conditions (69%), and laboratory test results (83%). Of individuals surveyed, 43% were willing to select their physician based on the availability of Internet systems (5).

Even Medicare beneficiaries have dramatically increased their use of the Internet, with 21.3% going online in 1999 compared to just 6.8% in 1997, according to the Medicare Current Beneficiary Study, conducted by the Centers for Medicare and Medicaid Services (22).

The June 2001 AMA report underscored the Harris poll's findings, stating: "A significant number of patients would like their physicians to provide certain medical services online . . . a growing number of patients are likely to have more of their medical care managed online in the future" (5).

B. Physician Use of the Internet Is Growing, though Growth in E-Mail Communication with Patients Has Hit a Barrier

Physician interest in utilizing the Internet as a tool for enhancing medical practice and communicating with patients is also well documented, according to the above AMA survey. This survey showed that 66% of physicians who used the Web considered it to be the most useful as a medical information source, and 51% found the Web useful as a drug information resource. A total of 39% of physicians considered the Web to be useful as a resource for patient education, and 21% consider the Web useful for marketing their practice. All of these figures have increased significantly over 1999 survey findings. The majority of physicians use the Web for medical information (85%), drug information (64%), and diagnostic decision analysis (52%) (5).

A total of 26% of physicians using the Web had a practice-related Web site, citing the provision of patient educational information and the marketing of their practices as primary reasons for having a Web site. The proportion of physicians who stated that the Web had had a major impact on the way that they practice medicine increased steadily since 1997 (1997—28%; 1999—33%; 2000—41%) (5). This finding is also supported by the November 2001 California HealthCare Foundation study, which found that, "Physicians believe the Internet will eventually radically improve communication with patients" (6).

The AMA survey cites many ways that online medical care will impact how physicians practice medicine:

> Patients with chronic conditions are likely to be continuously linked to a network, their conditions monitored by sensors and computers they carry as part of their clothing or themselves. Physicians will increasingly use encrypted e-mail for scheduling appointments, prescribing, sending laboratory reports, and reminding and alerting patients about new diagnostic and therapeutic approaches and newly identified side effects of drugs. While not standard practice at this time, physicians may consider treating common diseases by e-mail as they have previously done by telephone. E-mail will be used as an adjunct to direct patient encounters, not instead of them.
>
> Personal digital assistants (PDAs) or handheld wireless devices are likely to hasten physicians' transition to the Internet because physicians can use these devices while actually seeing patients. PDAs currently enable physicians to check drug doses, side effects, and dangerous interactions. Other current applications include the following: access to medical articles, prescription writing, treatment recommendations, sending information to patients' personal Web pages, and voice dictation. In the near future, physicians will use PDAs to directly transmit prescriptions to a pharmacy. Eventually, such devices will immediately alert physicians to changes in a patient's blood pressure or heart rate.
>
> Physician practices will increasingly provide highly customized and interactive Web-based services to patients, such as disease management tools, patient care protocols, e-mail to staff and physicians, and physician-supervised online support groups (5).

Despite all of this promise, growth in e-mail communication between physicians and patients is being stifled by lack of reimbursement (7, 9, 17, 18), with the percentage of physicians using this tool holding at a flat 13% from 1999 to 2001, according to a February 2001 Harris Interactive survey (19). The bottom line, according to industry experts, is that "patient-to-provider electronic communications won't go anywhere until there is reimbursement" (4).

V. The Benefits of Caring for Patients Online

Assuming that care rendered within the framework of the established physician–patient relationship over the Internet is duly reimbursed and limited to provision of nonurgent medical care and patient oversight, the result is a sizable number of benefits for patient and physician alike.

A. Reduction of Unnecessary Office Visits and Resultant Patient Cost Savings

An estimated 20% of the 830 million annual office visits per year could be eliminated by online communications between clinicians and patients, according to *Healthcast 2010* (3). With each visit averaging about $63, about $7 billion could be saved each year in clinical messaging (4). This does not even account for the large number of sick days and lost job productivity that patients could avert by not making an office visit.

B. Increased Practice Efficiency and Productivity and Lowered Operating Costs

Online communication can increase practice efficiency and productivity through fewer telephone calls, decreased administrative costs, and growth through attraction of new patients. E-consults are far less disruptive than phone calls, are performed at the physician's convenience, and are relatively inexpensive and self-documenting (6). Thus, office visits would be reserved for those patients truly requiring face-to-face care, as well as new patients.

Also, many functions previously handled only by telephone or face-to-face encounter can now be accomplished through Internet communication: patient scheduling, prescribing of medications, monitoring of patients with chronic conditions (including transmission of data from electronic home monitoring equipment, which provides "virtual office visits" by sending data over the Internet on heart and device functioning from an implantable cardiac device) (6, 23). (See comments on disease management, below.)

C. Making Necessary Office Visits More Productive and Less Time Consuming

Obtaining important clinical information before an office visit can save time and make the face-to-face encounter more productive. This also translates to less cluttered waiting rooms, shortened waiting times, and more satisfied patients (24).

D. Online Communication Helps Patients Reach Their Physicians More Easily because It Gives Them an Alternative to the Phone (24)

E. Providing Helpful E-Mail Replies Takes Comparatively Little Patient Time, and It Increases the Likelihood that Patients Will Get the Right Information (24)

F. Being Available Online Makes Communication More Convenient for Patients and Makes Patients Feel a Special Connection with Their Physician, Increasing Patient Satisfaction and Retention (6, 24)

G. Ability to Monitor Patients and Provide Follow-up Care without Additional Office Visits (6)

H. The Management of Chronic Illness, Also Known as Disease Management, is One Area of Medicine in which Expanded Use of Electronic Communications Can Have a Major Impact

According to a November 2001 California HealthCare Foundation report on "E-Disease Management":

> By 2010, 40% of Americans will suffer from a chronic disease. Already, caring for the chronically ill consumes a disproportionate share of national spending on health care. Organized efforts to better serve these patients and bring down the costs of their care through disease management programs began a decade ago. Sponsored by both health plans and provider organizations, early programs had limited information technology to aid physicians and other caregivers in managing patients with complex needs or to support them in managing their own health care. Web technology now offers tools for disease management that are cheaper and more accessible than both paper-based systems and traditional information technology.
>
> Two-thirds of health plans use some form of disease management to proactively coordinate patient care and promote patient self-management. With the potential to cut direct medical expenditures, improve health status, build patient and physician loyalty, and reduce lost work days, both health care providers and employers also are increasing their use of organized disease management to provide care and support to the chronically ill . . . it should be no surprise that applying Web-based tools to disease management—"e-disease management"—is one of the most active areas for leveraging the Internet in health care (25).

The Centers for Medicare and Medicaid Services (CMS) is conducting a number of disease management/coordinated care demonstration programs to determine whether such programs should be used to care for Medicare patients with chronic illnesses who are not members of Medicare+Choice plans. Monitoring of such patients electronically is a vital component of disease management, and CMS would have to establish a mechanism for paying physicians who provided such oversight under Medicare's fee-for-service component.

In the last year, CMS has taken other positive steps in terms of paying physicians for non–face-to-face patient monitoring, reviewing patient data collected by sensors outside the office. This includes increasing physician reimbursement for reading downloads of patient glucose levels captured by a subcutaneous sensor and instituting physician payment for review of blood pressure data for "white coat hypertension" patients, which is collected and stored by a noninvasive device. ACP commends these first steps and believes they will complement our recommendations concerning reimbursement of online patient consults and monitoring.

VI. Concerns/Solutions Related to Expanded Use of Online Communication for Patient Care Purposes

Potential gains in office efficiency and productivity could be offset by start-up costs for implementing new technology, possible lost revenue due to declines in office visits, inappropriate utilization by patients, and a new set of legal and compliance issues surrounding physician liability and maintaining confidentiality of patient information.

A. Concern: Physicians' Financial Well-Being, Already Threatened by Medicare Reimbursement Cuts, Could Be Further Jeopardized by a Decline in Reimbursable Office Visits

How bad is the financial climate for physicians? One state medical association survey showed a 13.9% drop in physician income from 1992 to 2000, while hours worked increased 6.7% over the same time frame (22). Another study showed physicians spending less time on providing charity care over a 3-year span between 1996 and 1999, with 4% of physicians discontinuing charity care entirely (26).

The Balanced Budget Act of 1997 (BBA) has exacerbated the physician's financial plight, with a 5.4% slash in Medicare physician pay implemented in 2002. This continues a trend in which physician practice costs have outstripped Medicare payments by 13% over the last 10 years, making it increasingly difficult to provide a level of service consistent with the highest standards of medical quality (27–30).

The combined impact of these Medicare cuts and declining office visits has placed physicians in serious financial peril. While many more patients could be effectively served through e-mail consults, until such care is appropriately reimbursed, most physicians will not be able to provide this service.

Solution: Instituting payment for physician care provided online. Until payment for non–face-to-face physician care is properly valued and becomes the norm, many physicians will be forced to avoid online patient contact. It is hoped that the trend started by private insurers in paying physicians for "e-visits" will lead Medicare to follow suit, allowing the benefits of 21st-century communications to reach its 34 million fee-for-service beneficiaries.

B. Concern: Cost and Inconvenience of Implementing Electronic Patient Communication

Physicians are not compensated for the start-up and ongoing operating costs of electronically interfacing with patients. This includes purchasing the necessary hardware and software, Internet service fees, establishing new internal operating procedures and training of staff, and installing new record-keeping systems to ensure that communications with patients are saved and filed.

Solution: The American Academy of Family Physicians (AAFP) indicates that "establishing a web presence is a relatively low-cost venture, whether you chose to set up and maintain your own site or hire someone to do it for you." The AAFP cites Web site development costs of $50 to $650, with monthly site maintenance and Internet e-mail account fees ranging from $5 to $45 (24). Obviously, electronic infrastructure costs will vary widely depending on the sophistication of services offered.

C. Concern: Compliance with Patient Privacy, Confidentiality, and Security Requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Physicians must assure that electronic communication with patients is performed on a secure Web site and that records of communication are protected in accord with the requirements of HIPAA.

Solution: Protection of patient confidentiality can be addressed with the development of secure Web sites for private patient–physician communication (11). Computer messages can be kept safe and confidential by storing them on secure computer servers that have security procedures, including the use of encryption, and firewalls in place to restrict unidentified parties from accessing the main and backup servers. In addition, user IDs and passwords are required to view both patient and physician messages.

D. Concern: Physicians Must Consider Medical Liability Risk Exposure Resulting from Online Communication with Patients

Physicians must keep in mind that providing online medical consultation to a patient constitutes a patient–physician relationship. As such, physicians are legally liable for medical advice dispensed by e-mail consultation and should determine if the levels of risk exposure and liability insurance are reasonable and cost-effective. A physician must also be mindful to restrict practicing medicine over the Internet to the state in which he/she is licensed.

Solution: Malpractice concerns have been greatly reduced through the issuance of "eRisk" guidelines for minimizing risk exposure, promulgated by two organizations: the American Medical Informatics Association and the well-respected multi-medical association consortium known as Medem (12) (31). In fact, one expert believes that ". . . e-mail will actually protect physicians against litigation because it's self documenting. . . . It will come to a physician's defense much better than a telephone call that wasn't documented thoroughly" (12).

E. Concern: Patients Could Abuse or Overutilize Electronic Communication with Physicians, Making It Harder to Serve the Most Needy Patients in a Timely and Effective Manner

In establishing a system of computer-based patient communication, it is vital that it be designed only for nonemergent or nonurgent consultations. In order to avert being overwhelmed with online patient inquiries, diverting precious time from seeing or communicating with those patients most in need, physicians will need to set up rules for patients to follow concerning appropriate uses of e-mail communication. To assure optimal use of physician time responding to patients over the Internet, incoming messages should be triaged by a nurse or trained office staff. Patients who continually violate online communication rules should be informed that such behavior will make them subject to discharge.

Solution: Employing structured clinical e-mail, already in use by a number of health insurers, helps ensure that medical information input by patients is thorough and complete, making it possible for physicians to quickly determine which patients are most in need of care and minimize the need for follow-up e-mails or phone calls (11).

VII. ACP Recommendations Regarding Payment for Physician Care Rendered Online

Recommendation 1:

ACP supports reimbursement by Medicare and other payers for health-related communication, consultations, and other appropriate services via the Internet, subject to guidelines on the level of work required for the service to be reimbursed as a separate service outside of the usual evaluation and management (E/M) service.

Recommendation 2:

Medicare and other payers should work with the physician community to develop guidelines on reimbursement of health-related communication, consultations, and other appropriate services via the Internet. The guidelines should include examples of both reimbursable and nonreimbursable Internet-related communication.

Recommendation 3:

Payment for health-related Internet communication should not result in a reduction in separate payments for evaluation and management (E/M) services. Such reimbursement should also not be subject to budget-neutrality offsets under the Medicare fee schedule.

As a starting point, ACP recommends that the following examples be considered for the development of guidelines regarding health-related communication:

a. Examples of Nonreimbursable E-Mail Services

Principles: Time involved is typically no more than 2 minutes and often can be delegated to staff after brief instructions; documentation typically is limited to a few words; minimum liability potential and no significant need for patient counseling.

1. Reporting normal test results (e.g., laboratory or x-ray studies) with no new, complex treatment or management decisions that need explanation or counseling.
2. An e-mail from a patient who is seen immediately thereafter as a result of this contact.
3. E-mail contact with another physician in reference to a patient.
4. Hospital service calls.
5. Routine renewal of drug prescriptions, orders, or noncritical decisions.
6. Confirming resolution of an acute, generally self-limited problem without indication of complication or relapse.
7. Brief follow-up of medical procedure to confirm stable condition, without indication of complication or new condition.
8. Answer a question regarding preparation for or details about a low-risk diagnostic test ordered in conjunction with, or arising out of, a recent, reimbursed service.

b. Examples of Reimbursable E-Mail Consultation Services

1. Services that involve a new diagnosis or require a new treatment (e.g., acute respiratory illness), when the equivalent service performed in person would have led to a service charge itself. If another evaluation and management service is performed that is essentially incidental to the condition treated via e-mail, there should not be separate service charges engendered. For example, if a urinary tract infection (UTI) is diagnosed by e-mail and a prescription is called in, the patient should not be charged for a separate office visit if he or she gives a urine sample at the office and has his or her temperature checked.
2. Follow-up maintenance services, such as management of insulin-dependent diabetics with multiple blood sugar checks and insulin changes or management of a hypertensive patient with multiple out-of-office blood pressure readings.
3. Treating relapses of a previous condition when this can be adequately assessed by e-mail, but a significant investment of physician time and judgment are involved (e.g., flare-up of irritable bowel, flare-up of gout with previous confirmed diagnosis).
4. Reporting laboratory results (for laboratory work not done in conjunction with an office visit) that require a significant change in medication or further diagnostic tests (e.g., addition of a second drug when treating hyperlipidemia, adjusting the dose of medication based on home glucose or blood pressure readings, or ordering and reporting gall bladder studies when liver functions are abnormal on routine studies).
5. Extended personal counseling of a patient who has previously been evaluated for a psychiatric problem in the office and is stable. This would also include evaluation of a patient for medication adjustment.
6. Nursing or rest home e-mail exchange when the patient has a significant change in condition, such as a change in vital signs or significant fall.
7. Extended counseling with family by e-mail (e.g., cases in which there are significant intrafamily conflicts or deficits in understanding related to a patient under direct care).
8. ACP also advocates Medicare coverage and payment for new CPT code 99091 to compensate physicians for review of computer-transmitted patient medical data for diagnostic/treatment purposes.
9. Answering questions about preventative health and interpreting literature that the patient has found in a magazine or on the Web.

Note Regarding Documentation: All e-mail physician consultation services that are billed should be documented on the patient's medical chart. This documentation should include the date of the contact, reason for the e-mail, diagnosis, treatment given, involved parties (if other than the patient), and follow-up instructions.

VIII. Conclusion

It is clear that rapid advances in computer technology have been increasingly accepted as a valuable tool for both physicians and patients alike. As access to computers and the Internet increases, along with further evolution of Web-based technology, usage will continue to expand, especially in the area of overseeing patients with chronic conditions.

This revolution in patient care management is only beginning to unfold. Potential gains in quality of care, office efficiency, and productivity must be balanced against start-up costs for implementing new technology, possible lost revenue due to reduced need for office visits, inappropriate utilization by patients, and a new set of legal and compliance issues surrounding physician liability and maintaining confidentiality of patient information.

Patient demand for online access to their physicians is strong and growing, and there is now solid evidence from the webVisit study (1) that care rendered in this manner can yield tremendous benefits for consumers, physicians, and the health care system at large. These benefits include reducing unnecessary office visits; serving patients' medical needs without the necessity and cost of an office visit; avoiding sick days and lost worker productivity; improving the efficiency of care provided in the office and lessening waiting times for appointments and in the office; helping physicians perform follow-up care; making oversight of chronic care patients easier and more effective; ensuring that care provided face-to-face is reserved for the patients most in need; and generally lowering the cost of ambulatory care by screening out patients who do not require a costly office visit and by being able to pay physicians for e-mail consults with established patients at a rate that is fair, but that is significantly less than an office visit.

Patients and physicians are ready for this major shift in how care is practiced. The only major remaining barrier is ensuring that care rendered online is properly valued and compensated. This is already happening in the private insurance market; ACP thus urges Medicare and other insurers to follow suit without delay and allow the benefits of 21st-century technology to help produce a healthier and more satisfied American public.

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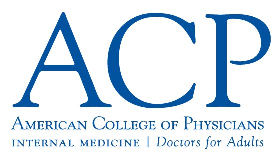

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