VERMONT MEDICAL SOCIETY RESOLUTION

Reimbursement to Physicians for Providing Non Face-to-Face Care

Adopted October 27, 2012

Whereas, Despite strong patient demand for care provided electronically and high levels of patient satisfaction, physicians under fee-for-service must limit their use of email and the telephone for patient care due to the general lack of reimbursement for non face-to-face care; and

Whereas, A study[1] of a community-based internal medicine practice published in the New England Journal of Medicine documented that telephone calls that were determined to be of sufficient clinical import to engage a physician averaged 23.7 per physician per day and physicians averaged clinically related 16.8 e-mails per day; and

Whereas, According to a study[2] published in Health Affairs, for patients with diabetes and hypertension the use of secure patient-physician e-mail was associated with an increased likelihood that patients would meet each of nine HEDIS measures and when compared to matched controls, the use of e-mail was associated with a 2.0–6.5 percentage-point improvement in HEDIS performance; and

Whereas, The five leading reasons for patients to e-mail their physicians were to report a change in a condition (16 percent), discuss lab results (14 percent), discuss a new condition (12 percent), discuss changes in prescription dose (11 percent), and discuss the need for a new prescription (10 percent);[3] and

Whereas, Nonfinancial barriers to the use of e-mail also exist due to the current quality measures used by HEDIS and the National Committee for Quality Assurance relying on face-to-face visits as the standard of care; and

Whereas, CPT codes 99371-99373 cover a "telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals, " however, Medicare and most other payers do not provide separate reimbursement for these codes; and

Whereas, Medicare currently pays physicians billing HCPCS codes G0181 or G0182 for the non face-to-face care plan oversight services (including telephone calls) furnished for patients under care of home health agencies or hospices;[4] and

Whereas, In order to improve transitions of care and reduce hospital readmissions, Medicare has proposed creating a new HCPCS G-code beginning in 2013 to pay community physicians to describe post-discharge transitional care management, including communication (direct contact,

[1] Baron R. What's Keeping Us So Busy in Primary Care? A Snapshot from One Practice. N Eng J Med 2010; 362: 1632-1636

[2] Zhou Y, Kanter M, Wang J, Garrido T. Improved Quality at Kaiser Permanente Through E-Mail Between Physicians and Patients. Health Affairs 29. No 7 (2010): 1370-1375

[3] Ibid

[4] 42 CFR Parts 410, 414, 415 *et al.* Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Federal Register Vol 77 No 146, pages 44722-45234. July 30, 2012

telephone, electronic) furnished to ensure the coordination and continuity of care for patients discharged from a hospital;[5] and

Whereas, CMS has explicitly constructed this proposal as a payment for non face-to-face post-discharge transitional care management services separate from payment for Evaluation and Management or other medical visits; and

Whereas, Patient attribution methods that support valid cost and quality metrics will be crucial to the development of an effective Accountable Care Organization models; and

Whereas, Those patients with no claims for traditional face to face office-based evaluation and management CPT codes but receiving email consultations or assistance by telephone should be attributed to the physician offering these services since unnecessary office visits may have been avoided and the attribution method should reward and encourage these types of services;[6] and

Whereas, At a time when primary care physicians are overwhelmed with non-reimbursable duties and U.S. medical-school graduates are avoiding traditional primary care specialties, it is urgent that policy makers and payers understand the actual work of primary care and find ways to support it through radical change in practice design and payment structure; now therefore be it

RESOLVED, The Vermont Medical Society will urge the General Assembly, the Green Mountain Care Board and the Department of Vermont Health Access to adopt policies for all payers that are at least consistent with Medicare and provide for the reimbursement for non face-to-face care; and be it further

RESOLVED, The Vermont Medical Society will work with the AMA and other physician organizations to urge the revision of current quality measures used by HEDIS and the National Committee for Quality Assurance to allow for the appropriate use of non face-to-face visits as the standard of care.

[5] Ibid

[6] Pantely S. Whose patient is it? Patient attribution in ACOs. Milliman Healthcare Reform Briefing Paper. Jan 2011