

September 10, 2018

RE: File Code CMS-1693-P  
Via Electronic Submission  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 8016  
Baltimore, MD 21244-8016

Re: Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2019 (CMS-1693-P)

Dear Sir/Madam:

The E-Consult Workgroup comprises over 50 organizations led by the Center for Connected Health Policy and seeks to advance the use of electronic consults (e-consults) across California and the nation. The Workgroup represents payers, providers, health policy leaders and patient advocates and works with stakeholders to advocate for public payer reimbursement and acknowledgement of e-consult programs in network reporting. We welcome the opportunity to provide these comments on the proposed Medicare Physician Fee Schedule for CY 2019 (PFS) published July 27, 2018.

**Adoption of the interprofessional internet consultation codes recognizes current medical practice trends and supports payment accuracy**

The Workgroup supports CMS's proposed efforts to expand the PFS to include services provided by telecommunications technology. This is particularly true for interprofessional internet consultations, which encompass e-consults. E-consults are documented interprofessional internet consultations, sent between a treating or requesting practitioner and a specialist, and may contain accompanying lab results, images or electronic health record notes, when necessary.

We agree with CMS's position that making separate payments for interprofessional internet consultations will contribute to payment accuracy for primary care and specialty care management services. Even more, we believe that it will reflect the recent shift towards increasing use of telecommunications services in medical practice. Performing interprofessional internet consultations—including e-consults—has become standard of practice for providers across the country, and public and private payers alike are increasingly covering these services for the benefit of plan members. In California, Medi-Cal managed care plans across the state are covering e-consults, and large academic medical centers like Zuckerberg San Francisco General and UC Davis have integrated performing e-consults as a required step in the referral process<sup>1</sup>.

Research suggests that e-consults assist providers in delivering efficient, high quality care to patients in varied settings, including those with chronic conditions. Primary care providers report high satisfaction with the consultations' response quality, quick turnaround time, and helpfulness in care management.<sup>2</sup> E-consult programs have been implemented around the country across nearly every specialty and setting, targeting chronic conditions such as pain and cardiovascular disease<sup>3</sup> and supporting patients in ambulatory settings<sup>4</sup>. Regardless of the specialty, e-consult

programs have been associated with patient and system-wide savings<sup>5</sup> through avoided travel and avoided opportunity costs through lost wages and productivity.<sup>6</sup>

Providers have also indicated that e-consults contribute to patient-centered care.<sup>7</sup> PCPs describe the value to e-consults bring to their patients, noting that patients appreciate the prevention of unnecessary wait times for specialty visits.<sup>8</sup> Patients themselves have reported high levels of satisfaction with e-consults, both overall and based on convenience.<sup>9</sup>

Including the interprofessional internet consultation codes in the Medicare PFS will more accurately recompense requesting or treating practitioners and specialists for time spent assessing cases. The historic practice of performing informal “curbside consults” via telephone has been shown to provide valuable information for PCP care management in a timely fashion.<sup>10</sup> However, curbside consults are not reimbursed or considered part of the practitioners’ work effort,<sup>11</sup> and may not include formal written documentation. Reimbursing practitioners for time spent on more formal consultations will more accurately recompense them for their time spent assessing cases while ensuring proper written documentation of the consultation in the patient’s electronic health record.

### **Interprofessional internet consultations are separately identifiable services from similar services for the benefit of the practitioner**

The primary purpose of interprofessional internet consultations, including e-consults, is to benefit the patient. Though commentary and research suggest that e-consults may improve communications between practitioners and may offer an educational benefit to PCPs,<sup>12</sup> the key driver of the spread of e-consults—and the mission of our Workgroup—is to benefit the patient with increased access to and decreased wait times for specialty care.<sup>13</sup> E-consults and other interprofessional internet consultations can also be distinguished from other telecommunications platforms like Project ECHO whose primary purpose is to provide an educational benefit for the provider.<sup>14</sup>

### **Payers and providers have successfully minimized program integrity issues**

Programs covering interprofessional internet consultations have controls in place to ensure that consultations are appropriately conducted and reimbursed. E-consults are used when reasonable and necessary, designed specifically for routine, non-urgent requests. Payers and providers determine which model best meets their needs: whether an e-consult is required or optional prior to a referral. As occurs with all other health care services offered, payers and providers determine appropriate arrangements for billing and payment, including incentives, bundled payments, or the use of CPT codes and their accompanying wRVUs, depending on the care setting and payment model. Programs have protections against fraud or self-referral, utilizing reporting tools to monitor provider activity, utilization and satisfaction with peer-to-peer interactions<sup>15</sup>. E-consults and other forms of interprofessional internet consultations have become standard of care, and they pose no greater threat to program integrity than do other health care services.

### **CMS should not require obtaining beneficiary informed consent for practitioners to perform an e-consult**

We disagree with CMS’ proposal to require that providers obtain verbal consent and document such consent prior to performing an interprofessional internet consultation. The Workgroup would like to stress that such consultations are performed between providers to facilitate any

further treatment or procedures that the beneficiary may need. Such a practitioner-to-practitioner communication would be exempt from informed consent, as the informed consent process is normally understood in the standard of care. CMS' Interpretive Guidelines for Informed Consent, as well as state law, assert that beneficiaries must provide informed consent prior to receipt of medical or surgical interventions.<sup>16</sup> However, practitioners are not required to obtain informed consent prior to engaging in consultative dialogue with their colleagues.

An interprofessional internet consultation is used as an appropriate and necessary step towards development of a PCP care plan or a referral. Since the PCP seeks advice as to how to proceed in treating a particular patient, the practitioner cannot fully apprise the beneficiary of the risks inherent to any treatment or procedure. In summary, we believe that the beneficiary's initial consent to receive an examination and any accompanying tests or work-up from the primary care practitioner satisfies the practitioner's ethical obligations regarding informed consent.

### **Proposed revisions to interprofessional internet consultation codes**

We recommend amending codes 99446-99449 to reflect that a written, rather than verbal, report is required. Requiring a verbal report in addition to a written report in the case of an electronically documented e-consult would be duplicative and inefficient and does not reflect how asynchronous internet consultations take place in practice. We agree that a written report should be required in providing each service for the purposes of auditing and maintenance of accurate patient records.

We also recommend amending codes 994X0 and 994X6 to contain the time-related language "for medical consultative discussion and review" contained in the 99446-99449 code set. We believe that adding this language would provide consistency across all codes used to reimburse treating or requesting practitioner and specialist time for interprofessional internet consultations, given that both practitioners engage in review and discussion. Relatedly, we recommend that code 994X0 be amended to strike the language regarding "referral services" and instead contain language similar to the other codes regarding "assessment and management" services to reflect the fact that not every consultation will result in a referral. These amendments would allow the codes to better reflect treating or requesting practitioner time engaging in back-and-forth consultative discussion, review and "closing the loop" for the benefit of a single patient's case.

#### *RECOMMENDATION: Amend Codes 99446-99449 as follows:*

Interprofessional telephone/internet assessment and management service provided by a consultative physician including a ~~verbal and~~ written report to the patient's treating/requesting physician or other qualified health care professional...

#### *RECOMMENDATION: Amend Code 994X6 as follows:*

Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative ~~time~~ **discussion and review**.

#### *RECOMMENDATION: Amend code 994X0 as follows:*

Interprofessional telephone/internet/electronic health record ~~referral services~~ **assessment and management request(s)** provided by a treating/requesting physician

or qualified health care professional, 30 minutes ***of medical consultative discussion and review.***

## **Proposed revisions to valuation of interprofessional internet consultation codes for CY 2019**

We recommend full adoption of the RUC's work RVUs for interprofessional consultation codes, specifically code 994X6. We believe that there is a lack of sufficient justification to reduce the wRVU for code 994X6 from 0.7 to 0.5, especially given that the RUC engages in highly technical and comprehensive assessment of services in providing their recommendations to CMS.

### **RECOMMENDATION: Replace RVU for Code 994X6 as follows:**

Replace the proposed 0.5 wRVU for 994X6 with an wRVU of 0.7.

### **Clarification of Qualified Locations**

Although the proposed PFS is silent as to limitations on what types of facilities may use the interprofessional internet consultation billing codes, we recognize that CMS has indicated limitations in other portions of the PFS. For example, with regard to remote evaluation of pre-recorded patient information, CMS notes several limitations to billing by federally-qualified health centers and rural health centers. We ask that CMS clarify that any outpatient or inpatient facility otherwise eligible to participate in the Medicare program may bill for interprofessional internet consultation services.

### **Beneficiary Copay Concerns**

The E-Consult Workgroup strongly recommends CMS waive copays for beneficiaries for all interprofessional internet consultations (codes 99446-9, 994X0 and 994X6). Requiring copays for consultations may cause confusion for beneficiaries who often have no formal relationship with the remote specialist practitioner conducting a consultation.

### **Conclusion**

The E-Consult Workgroup supports CMS's efforts to include the interprofessional internet consultation codes in the CY 2019 Medicare PFS. We support CMS's assertion that including these codes will more accurately reflect medical practice and support beneficiaries with chronic conditions, patient-centered care and accurate provider compensation. However, the Workgroup objects to the proposed consent requirements and recommends editing the code language for clarity and consistency. We also recommend full adoption of the RUC's wRVUs, which requires amending the proposed wRVU for code 994X6 in the proposed PFS.

We appreciate your consideration of our comments. If you have questions about these comments, please contact Libby Sagara at [libby.sagara@bluepathhealth.com](mailto:libby.sagara@bluepathhealth.com).

Respectfully submitted,

The Center for Connected Health Policy E-Consult Workgroup

**Endorsements included on page 5.**

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- <sup>1</sup> Alice Hm Chen et al., *eReferral, a New Model for Integrated Care*, 368 N Engl J Med 2450 (2013).
- <sup>2</sup> Clare Liddy et al., *Impact and Satisfaction with a New eConsult Service: A Mixed Methods Study of Primary Care Providers*, 23 J. Am. Board Family Med., 394 (2015).
- <sup>3</sup> Community Health Center, News Release, *Harvard Pilgrim Health Care Grants Supports Weitzman Institute Community eConsult Network Pilots in CT* (January 3, 2018), available at <https://www.chc1.com>.
- <sup>4</sup> Melissa Afable et al., *Innovative Use Of Electronic Consultations In Preoperative Anesthesiology Evaluation At VA Medical Centers in New England*, 37 Health Affairs 37, 275 (2018).
- <sup>5</sup> Anderson, D., Villagra, V., Coman, E.N., Zlateva, I., Hutchinson, A., Villagra, J. and Olayiwola, J.N., 2018. A cost-effectiveness analysis of cardiology eConsults for Medicaid patients. *The American journal of managed care*, 24(1), pp.e9-e16.
- <sup>6</sup> Clare Liddy et al., *What are the cost savings associated with providing access to specialist care through Champlain BASE eConsult service? A costing evaluation*, 6 BMJ Open e010920 (2016).
- <sup>7</sup> Clare Liddy et al., *supra* note 1.
- <sup>8</sup> *Id.*
- <sup>9</sup> Jason H. Wasfy et al., *Initial Results of a Cardiac E-Consult Pilot Program*, 64 J. Am. Coll. Cardiology 2706 (2014); Ted E. Palen et al., *Comparing virtual consults to traditional consults using an electronic health record: an observational case-control study*, 12 BMC Med. Informatics Decision Making 65 (2012).
- <sup>10</sup> Paul N. Gorman et al., *Can primary care physicians' questions be answered using the medical journal literature?*, 82 Bull Med Lib. Assoc. 140 (1994); Steven E. Wegner et al., *Estimated Savings From Paid Telephone Consultations Between Subspecialists and Primary Care Physicians*, 122 Pediatrics e1136 (2008).
- <sup>11</sup> Christopher Grace et al., *The Complexity, Relative Value, and Financial Worth of Curbside Consultations in an Academic Infectious Diseases Unit*, 51 Clin. Infectious Disease 651 (2010).
- <sup>12</sup> Alice Hm Chen et al., *Improving Primary Care-Specialty Care Communication: Lessons From San Francisco's Safety Net*, 171 J. Am. Med. Assn. Internal Med. 65 (2011); Rajeev Chaudry et al., *Physician perspectives on electronic consultations for specialty care delivery for patients: implications for person-centered medicine*, 2 Int'l J. Person Centered Med. 453 (2012).
- <sup>13</sup> Several studies have noted the associated benefit for patients via decreased wait times and decreased number of unnecessary specialty visits. See, e.g., Erin Keely et al., *Utilization, Benefits, and Impact of an E-Consultation Service Across Diverse Specialties and Primary Care Providers*, 19 Telemedicine J. & E-Health 733 (2013); Alice Hm Chen et al., *A Safety-Net System Gains Efficiencies Through 'eReferrals' to Specialists*, 29 Health Affairs 969 (2010)
- <sup>14</sup> Project ECHO is a live video platform that allows specialists in urban areas to offer educational training to rural primary care providers. For more information on Project ECHO, visit <https://echo.unm.edu>.
- <sup>15</sup> Keri L. Rodriguez et al, *Veteran, primary care provider, and specialist satisfaction with electronic consultation*, 3 JMIR Med Inform. e5 (2015).
- <sup>16</sup> See CMS, Interpretive Guidelines for Informed Consent § 482.13(b)(2). There, CMS notes that the "... right to make informed decisions regarding care presumes that the patient has been provided information about his/her health status, diagnosis and prognosis. Furthermore, it includes the patient's participation in the development of the plan of care, including providing consent to, or refusal of, medical or surgical interventions, and in planning for care after discharge."
- See also California case law on the definition of informed consent. "*When a doctor recommends a particular procedure then he or she must disclose to the patient all material information necessary to the decision to undergo the procedure...*" (emphasis added) *Mathis v. Morrissey*, 11 Cal.App.4th 332, 343 (1992).