Internet based eye care

Reimbursement for internet based eye care

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How long should we wait?

Medicare, Australia's universal health insurance system, assures access to public health services. Although it is now 20 years since Medicare was introduced, marginal improvements to Medicare are indicated.[1] Fulfilling the specialist healthcare needs of millions of rural Australians is crucial to the debate over Medicare's future. Clinicians in Australia are worried about inequity in terms of access and outcome for their patients and are willing to be partners in healthcare governance to improve the situation.[2] Yet, services like internet based eye care, with a wide range of usages, are candidates for regulation.[3] The term internet based eye care refers to the delivery of eye care services, especially to remote and rural communities, by means of modern telecommunications technology.[4]

Meanwhile, in the United States, the Congress has acknowledged internet based healthcare as a viable, potentially life saving technology.[5] Payers are signing on to this trend, as major medical centres come to see the benefits. Beginning in October 2001, the Health Care Financing Administration (HCFA) extended Medicare coverage to a wide range of internet based healthcare services and providers, allowing for medical visits, consultations, mental health services, and pharmacological monitoring of patients living in rural areas.[6] Payment to providers was at a rate similar to that paid without the use of internet based care. Furthermore, Medicare paid a facility fee of $20 per internet based care session to the originating site in the remote region. Internet based care services are well integrated to regular healthcare systems in Scandinavian countries.[5]

In Australia, integration of internet based eye care to the healthcare system may become more feasible by reimbursing this service.[2 7] Currently, with some exceptions, Australia does not have precise policies to reimburse for internet based eye care services. For example, Medicare reimburses for some services that do not require face to face contact between a patient and practitioner, such as radiology or pathology interpretation. As a result, other internet based healthcare specialty services have not found a firm financial foothold, and are primarily sustained through grants and short term funding.[7]

Initially, in the United States, the debate centred on whether ''Medicare should pay for internet based care services'' and then shifted to ''how Medicare should pay for internet based care services.''[8] Later, it became very important to understand ''why the program was not working and how to fix it.''[8] Learning from these US experiences can lead us to recognise what needs to be considered while formulating future Medicare payment programmes for internet based eye care in Australia. There is a need to examine and debate what form of internet based eye care reimbursement system is required in Australia. These discussions are vital to work towards proposing Medicare payment guidelines for internet based eye care.

WHO ARE ELIGIBLE?

In Australia, there are several remote, rural regions that have adequate primary care resources but lack essential specialty services. For example, a rural region may have a nurse or general practitioner, but not cardiologists or ophthalmologists. These rural communities may greatly benefit by having access to specialists via internet based eye care,[9] but providers servicing them cannot be reimbursed under the current provisions. Nevertheless, restriction of coverage only to rural societies may severely narrow the applicability of internet based eye care. Poor health and inadequate public transportation can pose hurdles to many urban/suburban residents as well. Hence, (proposal 1) internet based eye care guidelines must clearly define who are eligible for such services.

SERVICES AND TECHNOLOGY

As mentioned earlier, Medicare currently reimburses some internet based care services that do not require direct patient-specialist contact such as teleradiology. For other specialties, the current definition of ''consultation'' limits the reimbursement to those encounters where the patient must be present. A growing number of internet based eye care programmes are using store and forward technology. These technologies engage asynchronous transmission of medical information to be reviewed later on by a physician at a distant site. The consultant reviews the cases without the patient being present in real time. A familiar illustration of a store and forward consultation occurs when a rural practitioner sends images of a retinal lesion to an ophthalmologist for diagnostic and management advice.[10] For many remote regional communities in Australia, store and forward may be the only reasonable way to practise internet based eye care.

In this scenario, Medicare coverage for store and forward technologies in Alaska and Hawaii may represent a significant outlook.[11] In Alaska, beginning in December 2002, over a period of 10 months, Medicaid has saved over US$30 000 in travel costs alone by using store and forward internet based health care.[12] Savings in lodging and per diem costs accentuate these savings, along with significant time saving to patients. This may suggest that requirements for a patient to be ''presented'' by a physician or practitioner at the originating site in real time must be avoided by legislation—unless medically necessary. The practitioner at the originating, distant site must make the decision of medical necessity. Consequently, (proposal 2) consistent definitions need to be developed regarding what constitutes a internet based eye care consultation.

Even once these definitions are developed, the question will remain on what basis should the payment be set? Should they be paid the same as for a face to face visit? Hence, (proposal 3) guidelines must clearly define what services are to be covered. The services covered may include consultations, medication management, and any additional services.

ELIGIBLE PRACTITIONER

Internet based eye care practitioners may be divided into referring practitioners and consulting practitioners. Eligible referring practitioners may include general practitioners and clinical nurses. But, in many instances, the referring practitioner is not present during the consultation. The patient is often ''presented'' by someone else like nursing assistants or healthcare technicians. Hence, (proposal 4) guidelines must clearly define the ''presenter'' as well as consulting specialist requirement.

To be reimbursed, presenters need to be an ''eligible'' referring practitioner.

PROCESS OF REIMBURSEMENT

One of the options is to split the teleconsultation fee equally among the referring practitioner and consulting specialist. However, this may prove to be troublesome and both parties may not accept the arrangement.[13] Alternatively, the consulting specialist could be paid the existing conventional consultation fee for the service provided. The originating site may receive a facility fee. Thus, (proposal 5) guidelines must clearly define internet based eye care payment methodology.

ISSUES AND ACTIONS

This discussion of reimbursement for internet based eye care may be only the beginning. Even before the guidelines are realised, it is apparent that some issues may be left unresolved. Studies should be conducted to monitor, evaluate, and refine the internet based eye care reimbursement process. Additionally, it should be noted that internet based eye care licensure and indemnity laws might also need to be formulated. This issue, however, remains a misty region for healthcare strategy that has implications for consulting specialist and ''eligible practitioners'' who practise across state or country lines.

Healthcare reforms are often slow because of varied factors. These may include a lack of commitment to change, resistance from vested stakeholders who fear losing some of their existing benefits, or failure by policymakers to translate successful aspects of the reforms into something tangible to the general public.[14] Medicare, internet based eye care service providers, and concerned institutions should convene to advance relationships leading to a workable model regarding internet based eye care service improvements. Several of these issues that call for deliberation within the dominion of internet based eye care in Australia may also be significant to other countries.

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REFERENCES

1 **Duckett S**. Medicare: where to now? *Aust Health Rev* 1995;**18**:117–24.
2 **Dwyer JM**. The next Australian health care agreements: what clinicians want? *Aust Health Review* 2002;**25**:17–23.
3 **Kovac M**. Rationing of hospital services in the Australian health system. *Croatian Med J* 1998;**39**:339–45.
4 **Jakobsen KR**. Space-age medicine, stone-age government: how Medicare reimbursement of internet-based eye care services is depriving the elderly of quality medical treatment. *Health Care Law* 2002;**274**:9–37.
5 **Gutierrez G**. Medicine, Medicare, the internet, and the future of internet-based eye care. *Critical Care Med* 2001;**29**(8 Suppl):N144–50.
6 **Health Care Financing Administration**. Revision of Medicare reimbursement for telehealth services (AB-01-69). Available at www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm (accessed June 2005).
7 **Sajeesh KR**, Yogesan K, Constable IJ. Should internet-based eye care be funded in Australia? *Med J Aust* 2004;**181**:583.
8 **Puskin DS**. Internet-based eye care: follow the money modalities. *Online Journal IssuesNursing*. 2000;**6**:2, available at nursingworld.org/ojin/topic16/tpc16_1.htm (accessed June 2005).
9 **Charles BL**. Internet-based eye care can lower costs and improve access. *Healthc Financ Manage* 2000;**54**:66–9.
10 **Sajeesh KR**, Mei-Ling TK, Constable IJ, *et al*. Internet based ophthalmology service: impact assessment. *Br J Ophthalmol* (in press).
11 **Health Care Financing Administration**. States where medicaid reimbursement of services utilizing internet-based eye care is available. Available at www.hcfa.gov/medicaid/telemed.htm (accessed June 2005).
12 **Stewart F**, John K, Vonne M, *et al*. Medicaid reimbursement in Alaska for store and forward internet-based eye care:critical analysis of data. *J Internet-Based Eye Care and E-Health* 2004;**10**:s–41.
13 **Tracy J**, McClosky AT, Sprang R, *et al*. Medicare reimbursement for telehealth: an assessment of telehealth encounters. University of Missouri. Available at telehealth.muhealth.org/geninfo/Telehealth%20Medicare%20Assessment%20July%20Dec%201999%20Final.pdf (accessed June 2005).
14 **Preker AS**. Global development challenges and health care reform. *World Hospital Health Service* 2001;**37**:2–8, 40, 42.