AMA
AMERICAN MEDICAL ASSOCIATION

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-14)
Coverage of and Payment for Telemedicine
(Reference Committee A)

EXECUTIVE SUMMARY

Telemedicine, a key innovation in support of health care delivery reform, is being used in initiatives to improve access to care, care coordination and quality, as well as reduce the rate of growth in health care spending. The evolution of telemedicine impacts all three strategic focus areas of the American Medical Association (AMA): improving health outcomes, accelerating change in medical education, and enhancing physician satisfaction and practice sustainability by shaping delivery and payment models.

The definition of telemedicine, as well as telehealth, has continued to evolve, and there is no consensus on the definition of either of the two terms. Today, there are three broad categories of telemedicine technologies: store-and-forward, remote monitoring, and (real-time) interactive services. The coverage of and payment for telemedicine services vary widely. While public and private payers have continued to develop formal mechanisms to pay for telemedicine services, inconsistencies remain that create barriers to the further adoption of telemedicine.

The standards of care and practice guidelines relevant to telemedicine are evolving and vary based on specialty and service provided. A number of national medical specialty societies have developed clinical guidelines and position statements addressing telemedicine while others have initiated steps to do so. Besides the specialty societies, the American Telemedicine Association (ATA)—an organization comprised of a cross-section of stakeholders including, for example, insurers, telecommunication providers, vendors, and individual physicians and other providers—has spear-headed a guideline development process for telemedicine with varying levels of engagement of medical specialty societies.

With a growing number of services being provided via telemedicine technologies, there is a need for a set of safeguards and standards in AMA policy to support the appropriate coverage of and payment for telemedicine services. In this report, the Council recommends a set of principles to ensure the appropriate coverage of and payment for telemedicine services. These principles aim to support future innovation in the use of telemedicine, while ensuring patient safety, quality of care and the privacy of patient information, as well as protecting the patient-physician relationship and promoting improved care coordination and communication with medical homes. Before physicians provide any telemedicine service, they should verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable.

Because the coverage of and payment for telemedicine services is related to the evidence in support of telemedicine, the report also includes recommendations supporting additional research, pilot programs and demonstration projects regarding telemedicine. In order to ensure quality of care, patient safety, and coordination of care in the provision of telemedicine services, the report's recommendations reiterate the importance of national medical specialty societies continuing to be involved in the development of appropriate and comprehensive practice parameters, standards and guidelines to address the clinical and technological aspects of telemedicine.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-14

Subject: Coverage of and Payment for Telemedicine

Presented by: Charles F. Willson, MD, Chair

Referred to: Reference Committee A
(Gary L. Bryant, MD, Chair)

Telemedicine, a key innovation in support of health care delivery reform, is being used in initiatives to improve access to care, care coordination and quality, as well as reduce the rate of growth in health care spending. The evolution of telemedicine impacts all three strategic focus areas of the American Medical Association (AMA): improving health outcomes, accelerating change in medical education, and enhancing physician satisfaction and practice sustainability by shaping delivery and payment models. This Council-initiated report provides background on the delivery of telemedicine; outlines coverage and payment rules of public and private payers addressing telemedicine; summarizes specialty society practice guidelines and position statements on telemedicine; highlights case studies on telemedicine; summarizes relevant AMA policy and presents policy recommendations.

BACKGROUND

In 1996, the Institute of Medicine (IOM) released its report "Telemedicine: A Guide to Assessing Telecommunications for Health Care," which defined telemedicine as "the use of electronic information and communications technologies to provide and support health care when distance separates participants." The IOM report on telemedicine also stated that:

> ... telemedicine is not a single technology or a discrete set of related technologies; it is, rather, a large and very heterogeneous collection of clinical practices, technologies, and organizational arrangements. In addition, widespread adoption of effective telemedicine applications depends on a complex, broadly distributed technical and human infrastructure that is only partly in place and is being profoundly affected by rapid changes in health care, information, and communications systems.[1]

Since the release of the IOM report, the definition of telemedicine, as well as telehealth, has continued to evolve, and there is no consensus on the definition of either of the two terms. Today, there are three broad categories of telemedicine technologies: store-and-forward, remote monitoring, and (real-time) interactive services.

Store-and-forward telemedicine involves the transmittal of medical data (such as medical images and bio signals) to a physician or medical specialist for assessment. It does not require the presence of both parties at the same time and has thus become popular with specialties such as dermatology, radiology and pathology, which can be conducive to asynchronous telemedicine.

Remote monitoring, or self-monitoring or testing, enables medical professionals to monitor a patient remotely using various technological devices. This method is typically used to manage chronic diseases or specific conditions (e.g., heart disease, diabetes mellitus, or asthma), as devices that can be used by patients at home to capture such health indicators as blood pressure, glucose levels, ECG and weight.

Interactive telemedicine services provide real-time, face-to-face interaction between patient and provider (e.g., online "portal" communications). Telemedicine, where the patient and provider are connected through real-time audio and video technology (generally a requirement for payment) has been used as an alternative to the traditional method of care delivery, and in certain circumstances can be used to deliver such care as the diagnosis, consultation, treatment, education, care management and self-management of patients.

COVERAGE OF AND PAYMENT FOR TELEMEDICINE

The coverage of and payment for telemedicine services vary widely. The passage of the Balanced Budget Act of 1997 and the Telemedicine Communications Act of 1996 enabled payment for professional telemedicine consultation in 1999. While public and private payers have continued to develop formal mechanisms to pay for telemedicine services, inconsistencies remain that create barriers to the further adoption of telemedicine.

Medicare

Each year, Medicare pays approximately $6 million for telemedicine services. In 2009, there were approximately 40,000 telemedicine visits, involving some 14,000 Medicare beneficiaries. That same year, 369 practitioners, including physicians, provided 10 or more telemedicine services to Medicare beneficiaries, most of which were mental health services. Psychiatrists, psychologists and clinical social workers comprised 49 percent of the practitioners who provided 10 or more telemedicine services in Medicare. While physician assistants, nurse practitioners and clinical nurse specialists accounted for 19 percent of such practitioners, family medicine and internal medicine physicians accounted for seven percent.[2]

Medicare provides payment to physicians and other health professionals for a relatively narrow list of Part B services that are provided via telemedicine. Eligible services include: initial and follow-up inpatient consultations; office or other outpatient visits; psychiatric diagnostic interview examinations; end-stage renal disease related services; neurobehavioral status exams; screenings for sexually transmitted infections (STIs) and high intensity behavioral counseling to prevent STIs; and intensive behavioral therapy for cardiovascular disease. In its final 2014 Physician Fee Schedule (PFS) rule, the Centers for Medicare & Medicaid Services (CMS) expanded telemedicine service codes that will be paid by Medicare to include transitional care management services (CPT codes 99495 and 99496). There is also an opportunity to request that services be added to the list of telemedicine services covered by Medicare, outlined at www.cms.gov/telehealth.

The originating sites where Medicare beneficiaries receiving services via telemedicine are located are limited to qualified centers in areas defined as rural Health Professional Shortage Areas (HPSAs), counties outside metropolitan statistical areas, and areas approved by the government for demonstration of telemedicine. Of note, in its Medicare 2014 PFS final rule, CMS expanded geographic locations where telemedicine services may be covered by Medicare by changing its definition of rural HPSAs to those located in rural census tracts as determined by the Office of Rural Health Policy.

The telemedicine services covered by Medicare are required to have both interactive audio and video with real-time communication. Coverage of store-and-forward telemedicine services is currently only allowed in Hawaii and Alaska as part of a demonstration program. Additional requirements for in-person visits exist for certain illnesses. Payment modifiers are used to code telemedicine services, and physicians are paid under the PFS. Physicians and other practitioners who provide a service via telemedicine must be paid an amount equal to the amount that the practitioner would have been paid if the service had been provided without the use of telemedicine. If a prescriber has reassigned billing rights to a Critical Access Hospital, payment is 80 percent of the Medicare PFS for telemedicine services.

Medicare Advantage plans are exempt from these limitations placed on telemedicine services provided to Medicare fee-for-service beneficiaries. The Council notes that there is increasing momentum in Congress to also exempt physicians and other health practitioners who participate in alternative payment models from the aforementioned telemedicine limitations that otherwise exist in Medicare.

Other Payers

Forty-six states and the District of Columbia (DC) offer some form of Medicaid payment for telemedicine services. While the Medicaid programs in all of these states and DC pay for some services administered via real-time audio and video technologies, the Medicaid programs in only nine states at some level pay for store-and-forward, and 14 states pay for remote patient monitoring.[3] In addition, 19 states and DC have adopted laws mandating that private payers cover what the states deem as telemedicine services (definitions vary by state).[4] State coverage of and payment for telemedicine services are related to state laws addressing what services providers can and cannot deliver remotely and what requirements need to be met in order to do so. The Council notes that there is little consistency among states in how telemedicine is defined and regulated.

Some of the leading private health insurers provide coverage and payment for telemedicine, with varying approaches to doing so. Some private insurers, including WellPoint, Aetna and Highmark have partnered with telemedicine companies that offer health consultations with very different technology models and standard operating procedures for interactions between patients and the health care providers. Examples of the significant variability in technology platforms and measures to facilitate care coordination include on one end of the spectrum, collaborations which offer two-way interactive video platforms and the ability to interact with a physician, and on the other end, partnerships with companies that primarily offer telephone communications between a patient and a health care provider.

SPECIALTY SOCIETY PRACTICE GUIDELINES AND POSITION STATEMENTS

The standards of care and practice guidelines relevant to telemedicine are evolving and vary based on specialty and service provided. The AMA has surveyed both national medical specialty societies and state medical associations concerning practice guidelines as well as policies broadly governing telemedicine. A number of specialty societies have developed clinical guidelines and position statements addressing telemedicine while others have initiated steps to do so. Examples of clinical guideline development include the American Academy of Child and Adolescent Psychiatry's practice parameter for telepsychiatry with children and adolescents, the Society of American Gastrointestinal and Endoscopic Surgeons' guidelines for the surgical practice of telemedicine, and the American College of Radiology/Society for Imaging Informatics in Medicine's practice guidelines for electronic medical information privacy and security.

Besides medical specialty societies, the American Telemedicine Association (ATA)—an organization comprised of a cross-section of stakeholders including, for example, insurers, telecommunication providers, vendors, and individual physicians and other providers—has spear-headed a guideline development process for telemedicine with varying levels of engagement of medical specialty societies. For example, the American Academy of Dermatology (AAD) provided input on the use of the Practice Guidelines for Teledermatology, developed by the ATA. The ATA also released practice guidelines for video-based online mental health services, which were developed with input from the American Psychiatric Association (APA). It is anticipated that national medical specialty societies will take a greater role in the development and approval of telemedicine clinical practice guidelines.

Along with many other specialty societies, including the American College of Physicians, the American Academy of Family Physicians, the American Osteopathic Association, and AAD, APA also has a position statement on the ethical use of telemedicine. The American College of Radiology also issued a white paper on teleradiology practice, and the Telemedicine Work Group of the American Academy of Neurology issued a report on teleneurology applications.

CASE STUDIES OF TELEMEDICINE

As outlined in the highlighted case studies below, there is a range of medical services being delivered via telemedicine by physicians and other health professionals. Telemedicine services are provided by hospitals, specialty departments, home health agencies and private physician offices. While some telemedicine programs are multispecialty in nature, others are tailored to specific diseases and medical specialties.

University of Virginia (UVA) Center for Telehealth

The UVA Center for Telehealth works across the UVA Telemedicine Partner Networks, which includes 118 sites to offer telemedicine services in more than 40 specialties and sub-specialties. Services provided include single consultations and follow-up visits, emergency consultations, and screenings using store-and-forward technologies, such as mobile digital mammography and retinopathy. Depending on the specialty, the patient may need to have an initial in-person visit with the specialist at UVA and then continue with follow-up appointments via telemedicine. The Center has provided more than 33,000 patient encounters in Virginia, and provides more than 30,000 teleradiology services per year.[5] The Center accepts referrals from other physicians, as well as direct appointments from patients. After the appointment with a physician of the UVA Center for Telehealth, to ensure continuity of care, the referring physician, if any, and/or the patient's primary care physician, is provided a report with follow-up information.

Arkansas ANGELS

The Antenatal & Neonatal Guidelines, Education & Learning System (ANGELS) of the University of Arkansas for Medical Services (UAMS) provides patients with around-the-clock and telemedical support to address high-risk obstetrical care needs. With approximately thirty telemedicine sites, ANGELS delivers subspecialty care services to high-risk mothers and their infants. Notably, UAMS houses many of state's only board-certified maternal-fetal medicine specialists and genetic counselors. ANGELS uses a variety of telemedicine technologies to deliver care, including specialized ultrasound equipment that digitally transfers a sonogram image to UAMS, as well as special devices to perform colposcopies via telemedicine to allow for remote cervical examination and biopsy. In 2012, there were 5,221 telemedicine visits as part of ANGELS, as well as 2,062

telemedicine obstetric ultrasound visits and 130 fetal echocardiogram visits. Also in 2012, 1,629 colposcopy exams were provided, which identified 303 women with high-grade lesions requiring treatment and five diagnosed with cancer.[6]

AccessDerm

AccessDerm is a teledermatology program sponsored by the AAD that provides primary care practitioners working in participating clinics caring for underserved patients with free access to dermatologic consultations of AAD members. The primary care practitioner and participating AAD-member dermatologist use either personal mobile devices or the Internet to transmit the information required for the consultation. AccessDerm consultations comply with HIPAA requirements for the privacy and security of patient information. As of the drafting of this report, 16 states have clinics registered to participate in the program. As of February 18, 2014, AccessDerm has provided more than 960 consultations to underserved patients, which have included diagnoses of a previously undiagnosed melanoma and a Kaposi's sarcoma.[7]

AMA POLICY

Payment

AMA policy states that physicians should uniformly be compensated for their professional services at a fair fee 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 (Policy H-390.859). Policy H-390.859 also calls for CMS and other payers to separately recognize and adequately pay for non-face-to-face electronic visits. Likewise, Policy H-480.961 states that CMS should reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" payment schemes. Policy H-480.974 states that the AMA will work with CMS and other payers to develop and test appropriate payment mechanisms for telemedicine through demonstration projects aimed at evaluating the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the patient-physician relationship. Policy H-385.919 supports pilot projects of innovative payment models being 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.

Clinical standards

Policies H-480.974, H-480.968 and H-480.969 encourage national specialties to develop appropriate and comprehensive practice parameters, standards and guidelines to address the clinical and technological aspects of telemedicine. Policy H-480.968 urges national private accreditation organizations to require that medical care organizations that establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery.

Licensure

Policy H-480.969 states that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, and outlines principles for any telemedicine license category. Policy D-480.999 opposes a single national federalized system of medical licensure. Policy H-160.937 outlines principles for the supervision of non-physician providers and technicians when telemedicine is used.

Ethical guidance

Opinion E-5.025, issued in 1994, prohibits physicians from providing any clinical services via telecommunications. As stated in Board of Trustees Report 22-A-13, this opinion may no longer be consistent with best ethical analysis or strong practice in the rapidly evolving area of telemedicine. As such, Policy D-480.974 states that the Council on Ethical and Judicial Affairs (CEJA) will review Opinions relating to telemedicine and update the Code of Medical Ethics as appropriate. A CEJA report examining ethical guidance in this area is in development.

DISCUSSION

As telemedicine continues to evolve, with a growing number of services being provided via telemedicine technologies, the Council firmly believes that there is a need for a set of safeguards and standards in AMA policy to support the appropriate coverage of and payment for telemedicine services. Such standards and safeguards need to support future innovation in the use of telemedicine, while ensuring patient safety, quality of care and the privacy of patient information, as well as protecting the patient-physician relationship and promoting improved care coordination and communication with medical homes.

Prior to delivering services via telemedicine, the Council believes a valid patient-physician relationship must be established, through at minimum a face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine. The face-to-face encounter could occur in person or virtually through real-time audio and video technology. Also, before a telemedicine service is provided, the physician or other health professional must notify the patient of cost-sharing responsibilities and limitations in drugs that can be prescribed via telemedicine. When a service is delivered using telemedicine, mechanisms to ensure continuity of care, follow-up care and referrals for emergency services must be in place.

The Council believes that key tenets in the delivery of in-person services hold true for the delivery of telemedicine services. Notably, physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and requirements as well as state medical practice laws including, for example, laws concerning consent involving minors, prescribing, reproductive rights, end-of-life, and scope. In addition, prior to the delivery of any telemedicine service, physicians need to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable. It is essential that patients have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.

The scope of the coverage of and payment for telemedicine services is directly correlated to the strength of the evidence base in support of telemedicine. While there is an emerging body of evidence suggesting that delivering services via telemedicine could contribute to improving patient

health outcomes, additional evidence needs to be compiled to ensure quality of care and patient safety. In addition to investing in research focused on the delivery of care via telemedicine, additional pilot programs and demonstration projects should be supported.

To ensure quality of care, patient safety, and coordination of care in the provision of telemedicine services, the Council believes it is essential for national medical specialty societies to continue to develop appropriate and comprehensive practice parameters, standards and guidelines to address the clinical and technological aspects of telemedicine, as called for in Policies H-480.974, H-480.968 and H-480.969. In addition, the Council notes that it is essential that specialty societies leverage, to the extent practicable, the work of national telemedicine organizations, including the ATA, in the area of technical standards and take the lead in the development of clinical practice guidelines for telemedicine.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That American Medical Association (AMA) policy be that telemedicine services should be covered and paid for if they abide by the following principles:

    a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
        - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine;
        - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
        - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

    Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

    b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.

    c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.

    d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.

    e) The delivery of telemedicine services must be consistent with state scope of practice laws.

    f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.

g) The standards and scope of telemedicine services should be consistent with related in-person services.
h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
j) The patient's medical history must be collected as part of the provision of any telemedicine service.
k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physician(s) and providing to the latter a copy of the medical record.
m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. That AMA policy be that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information. (New HOD Policy)

3. That our AMA encourage additional research to develop a stronger evidence base for telemedicine. (New HOD Policy)

4. That our AMA support additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine. (New HOD Policy)

5. That our AMA support demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models. (New HOD Policy)

6. That our AMA encourage physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service. (New HOD Policy)

7. That our AMA encourage national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines. (New HOD Policy)

8. That our AMA reaffirm Policies H-480.974, H-480.968 and H-480.969, which encourage national medical specialty societies to develop appropriate and comprehensive practice parameters, standards and guidelines to address the clinical and technological aspects of telemedicine. (Reaffirm HOD Policy)

Fiscal Note: Less than $500

REFERENCES

[1] Institute of Medicine. Telemedicine: A Guide to Assessing Telecommunications for Health Care. 1996. Available at: http://www.nap.edu/catalog.php?record_id=5296.
[2] Institute of Medicine. The Role of Telehealth in an Evolving Health Care Environment: Workshop Summary. 2012. Available at: http://www.iom.edu/Reports/2012/The-Role-of-Telehealth-in-an-Evolving-Health-Care-Environment.aspx.
[3] National Telehealth Policy Resource Center. State Telehealth Laws and Reimbursement Policies: A Comprehensive Scan of the 50 States and the District of Columbia. February 2014. Available at: http://telehealthpolicy.us/sites/telehealthpolicy.us/files/uploader/50%20State%20Scan%20February%202014%20Final.pdf.
[4] National Conference of State Legislatures. State Coverage for Telehealth Services. Available at: http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx.
[5] Rheuban, K. Telehealth in an Evolving Healthcare Environment. Presentation to AMA Councils. November 15, 2013.
[6] University of Arkansas for Medical Services ANGELS. 2012 Annual Report. Available at: http://angels.uams.edu/files/2010/12/Angels-Annual-report-2012.pdf.
[7] American Academy of Dermatology. AccessDerm Teledermatology Program. Available at http://www.aad.org/members/volunteer-and-mentor-opportunities/accessderm-teledermatology-program.

Federation of STATE MEDICAL BOARDS

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup

Adopted as policy by the Federation of State Medical Boards in April 2014

INTRODUCTION

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the "Model Guidelines for the Appropriate Use of the Internet in Medical Practice" (HOD 2002)[1] and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards") based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients[2] via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

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[1] *The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Modal Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).*

[2] *The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.*

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Model Guidelines for State Medical Boards' Appropriate Regulation of Telemedicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider.[3] However, state medical boards, in fulfilling their duty to protect the public, face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the prescribing and dispensing of certain medications.

The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these technologies can enhance medical care by facilitating communication with physicians and their patients or other health care providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice.[4]

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.[5]

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;

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[3] *See Center for Telehealth and eHealth Law (Ctel), http://ctel.org/ (last visited Dec. 17, 2013).*

[4] *Id.*

[5] *See Cal. Bus. & Prof. Code § 2290.5(d).*

- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

Section Two. Establishing the Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.[6] The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

Section Three. Definitions

For the purpose of these guidelines, the following definitions apply:

"Telemedicine" means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.[7]

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.

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[6] *American Medical Association, Council on Ethical and Judicial Affairs, Fundamental Elements of the Patient-Physician Relationship (1990), available at http://www.ama-assn.org/resources/doc/code-medical-ethics/1001a.pdf.*

[7] *See Ctel.*

Section Four. Guidelines for the Appropriate Use of Telemedicine Technologies in Medical Practice

The [Name of Board] has adopted the following guidelines for physicians utilizing telemedicine technologies in the delivery of patient care, regardless of an existing physician-patient relationship prior to an encounter:

Licensure:
A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.[8]

Establishment of a Physician-Patient Relationship:
Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship consistent with the guidelines identified in Section Two, and, while each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.

Evaluation and Treatment of the Patient:
A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:
Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician's credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

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[8] *Federation of State Medical Boards, A Model Act to Regulate the Practice of Medicine Across State Lines (April 1996), available at http://www.fsmb.org/pdf/1996_grpol_telemedicine.pdf.*

Continuity of Care:
Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient, and subject to the patient's consent, any identified care provider of the patient immediately after the encounter.

Referrals for Emergency Services:
An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

Medical Records:
The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records & Exchange of Information:
Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information," issued by the Department of Health and Human Services (HHS).[9] Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional face-to-face encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory

[9] *45 C.F.R. § 160, 164 (2000).*

results must be secure within existing technology (i.e. password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:
Online services used by physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated physicians;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Online services used by physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the site and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Advertising or promotion of goods or products from which the physician receives direct remuneration, benefits, or incentives (other than the fees for the medical care services) is prohibited. Notwithstanding, online services may provide links to general health information sites to enhance patient education; however, the physician should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, physicians should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of preferred relationships with any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit form that pharmacy.

Prescribing:

Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by [Name of Board].

Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

Section Five. Parity of Professional and Ethical Standards

Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC). There should be parity of ethical and professional standards applied to all aspects of a physician's practice.

A physician's professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies.

REFERENCES

American Accreditation HealthCare Commission. *Health Web Site Standards*. July 2001.

AMA. Council on Ethical and Judicial Affairs. *Code of Medical Ethics*. 2000-2001.

AMA. *Report of the Council on Medical Service*. Medical Care Online. 4-A-01 (June 2001).

College of Physicians and Surgeons of Alberta. *Policy Statement. Physician/Patient Relationships* (February 2000).

Colorado Board of Medical Examiners. *Policy Statement Concerning the Physician-Patient Relationship*.

The Department of Health and Human Services, HIPPA Standards for Privacy of Individually Identifiable Health Information. August 14, 2002.

FSMB. *A Model Act to Regulate the Practice of Medicine Across State Lines*. April 1996.

Health Ethics Initiative 2000. eHealth Code of Ethics. May 2000.

Health on the Net Foundation. *Code of Medical Conduct for Medical and Health Web Sites*. January 2000.

La. Admin. Code tit. 46, pt. XLV, § 7501-7521.

New York Board for Professional Medical Conduct. Statements on Telemedicine (draft document). October 2000.

North Carolina Medical Board. Position Statement. Documentation of the Physician-Patient Relationship. May 1, 1996.

Oklahoma Board of Medical Licensure. Policy on Internet Prescribing. November 2, 2000.

South Carolina Board of Medical Examiners. Policy Statement. Internet Prescribing. July 17, 2000.

Texas State Board of Medical Examiners. Internet Prescribing Policy. December 11, 1999.

Washington Board of Osteopathic Medicine and Surgery. Policy Statement. Prescribing Medication without Physician/Patient Relationship. June 2, 2000.

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