The growth of technology is fueling interest in telemedicine. Although telemedicine has been around for approximately 40 years, it will likely become more widespread as regulators move to ease some of the barriers to telemedicine practice. In the future, telemedicine could prove to be a powerful tool to increase the accessibility of health care and keep health care costs down.

The American Telemedicine Association (ATA) defines “telemedicine” as “the use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health status.” According to the ATA, telemedicine includes a growing variety of applications and services using two-way video, email, smartphones, wireless tools, and other forms of telecommunications technology. Many services can be furnished by telemedicine, including primary care and specialist referral services provided by live interactive video or transmission of images and information; remote patient monitoring; and medical education.

Recent newspaper articles describe some of the innovative ways that telemedicine is being used to deliver health care. The New York Times described a project, known as Project ECHO (short for Extension for Community Healthcare Outcomes), that uses remote technologies to link primary care doctors at the patient’s location with specialists who are based elsewhere. This project started out treating hepatitis C patients in New Mexico and has branched out to 26 specialties with ECHO hubs at 31 universities. The ECHO model uses video conferencing to conduct case-based training, collaborative care, and patient tracking. Another article describes how a Nantucket hospital uses telemedicine so that doctors can examine patients without having to travel to the island. Two dermatologists in Boston were able to diagnose and treat a patient at the Nantucket hospital. Using cameras and screens, a nurse held a magnifying camera to a patient’s face and the image was transmitted to the Boston dermatologists.

Despite these articles describing the benefits of telemedicine, barriers remain to its widespread use. Reimbursement remains an obstacle for telemedicine growth as there are specialized reimbursement rules for Medicare, state Medicaid programs, and private insurance. Medicare pays physicians and other health care professionals for certain Part B services provided by telemedicine. Generally, the services must be delivered via an interactive telecommunications system, which is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician and practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system. Finally, Medicare limits coverage of telemedicine services by geographic area, restricting it to a rural health professional shortage area, a county outside metropolitan statistical areas, and areas approved by the government as telemedicine demonstration areas. 42 C.F.R. § 410.78.

On July 11, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule expanding the list of Medicare-covered telemedicine services. In addition, the rule incorporates a CMS policy change effective January 2014 that expanded the definition of “rural” to include geographic areas located in rural census tracts within metropolitan statistical areas. Comments on the proposed rule were due on September 2, 2014, and CMS will publish the final rule later in 2014 with an effective date of January 1, 2015.

State Medicaid coverage of telehealth services varies greatly. As of July 1, 2006, Colorado no longer requires in-person contact between a health care or mental health care provider and a patient in order to receive Medicaid reimbursement for services delivered through telemedicine, as long as the services are otherwise eligible for reimbursement. C.R.S. § 25.5-5-320. On the other hand, there are still a few states that do not cover telemedicine services or cover very limited services. Idaho, for example, limits Medicaid payment for telehealth
services to psychiatric services for diagnostic assessments, pharmacological management, and psychotherapy with evaluation and management services 20 to 30 minutes in duration. Idaho Admin. Code Dept. of Health & Welfare § 16.03.09.502.

There have been several recent efforts to strike down barriers to telemedicine. In 2011, CMS issued a final rule implementing a new credentialing process for physicians and other practitioners in hospitals and critical access hospitals providing telemedicine services. The final rule, designed to remove barriers to the use of telemedicine, allows the hospital (or critical access hospital) to rely upon the credentialing and privileging decisions made by the telemedicine distant-site entity when making credentialing and privileging decisions for the distant-site physicians and practitioners.

On September 5, 2014, the Federation of State Medical Boards announced it had completed the drafting process for a model Interstate Medical Licensure Compact to streamline the licensing process and allow physicians to become licensed in multiple states. The compact also adopts the prevailing standard for licensure: The practice of medicine occurs where the patient is located at the time of the encounter. Thus, the physician must be under the jurisdiction of the state medical board where the patient is located. The compact, if adopted, could make it easier for physicians to treat patients in other states through telemedicine. State legislatures and medical boards can begin to consider adopting this legislation. The compact is located on the federation’s web page.

Finally, in June 2014, the American Medical Association (AMA) adopted a telemedicine policy to improve access to care for patients. The AMA report calls for telemedicine services to be covered and paid for if they abide by certain principles. Among the principles listed by the AMA are the following:

- A valid patient-physician relationship must be established before providing telemedicine services.
- Physicians and other health care practitioners delivering telemedicine services must abide by state licensure and medical practice laws in the state where the patient receives services.
- Physicians and other health care 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.
- The delivery of telemedicine services must be consistent with state scope of practice laws.

As telemedicine continues its growth, providers should keep aware of changing regulations, particularly in the licensure and reimbursement areas.

FILED UNDER MEDICAL LICENSING, REIMBURSEMENT, TELEMEDICINE

0 Comments Colorado Health Care Law Blog Login

Sort by Best Share Favorite 9

Start the discussion...

Be the first to comment.

Subscribe Add Disqus to your site

Address
Gordon & Rees LLP
Denver
555 Seventeenth St.
Suite 3400
Denver, CO 80202
Phone: 303.534.5160
Fax: 303.534.5161
www.gordonrees.com

About Gordon & Rees
Gordon & Rees is a national litigation and business transactions firm with more than 550 attorneys in 32 offices across 20 states. We deliver maximum value to our clients by combining the resources, size, and scale of a full-service national firm with the responsiveness, flexibility, and local knowledge of a regional firm.

Recent Posts
Regulatory Issues and the Growth of Telemedicine
Colorado Proposes Changes to General Licensure Rules Concerning Review and Approval of Quality Management Plans for Health Care Entities
CMS Plans to Expand Five-Star Rating System Beyond Nursing Homes
Medicare Advantage Risk-Adjustment Fraud – Where’s the False Claim? (Part I)
Face-to-Face Documentation Remains Home Health Compliance Risk Area