Utah Medical Association

Michelle S. McOmber, MBA, CAE
Chief Executive Officer

July 16, 2014

Health and Human Services Committee
Utah Legislature

UMA Stance on Telemedicine/Telehealth

To Whom It May Concern:

Thank you for giving the Utah Medical Association (UMA) the opportunity to comment on the planning, delivery and oversight of Utah's digital health services infrastructure or as it is more commonly known "telehealth." In addition to telehealth we would like the discussion to include the whole spectrum of telemedicine which includes all technologies that can be used in the delivery of health care services and communication/interaction between the patient and the physician as part of those services in health care today and into the future. We thank Representative Menlove for running the telehealth bill this past session and kicking off this important discussion.

As we build a fully robust telehealth/telemedicine system, we need to include all forms of telemedicine technologies in the discussion so that as technologies evolve and change, our health care system in Utah can evolve and change in the appropriate way with them and we can continue to have a high quality of health care service delivery in Utah. In addition to the discussion on how the services are delivered and how communication/interaction takes place between both the physician and the patient and between physicians for the care of the patient, we need to include the discussion on who will pay for these services or how they can be billed. If we do not discuss and resolve the pay for issue, we will not be able to move forward with a robust telehealth/telemedicine system.

We fully support further developing and using, as appropriate, a telehealth/telemedicine system in Utah that full utilizes existing and future technologies. We believe that health care and medicine must evolve with the times to take advantage of the technologies available to the fullest extent possible to provide the best access and care to the greatest number of individuals. By using the technologies available to us today in an appropriate manner, we can spread the resources we have to more individuals, particularly in mental health services and actually reduce costs. Just because this is a new and emerging way to deliver health care does not mean that quality of care should suffer or that care should be provided by individuals that are not qualified to give the care. In fact, we should be very careful in the design an implementation to make sure that care is given by the appropriate individual in the appropriate setting at the appropriate time.

310 East 4500 South, Suite 500
Salt Lake City, UT 84107-4250
www.utahmed.org

phone: (801) 747-3500
fax: (801) 747-3501
email: uma@utahmed.org

Telehealth can be a particularly useful tool in the delivery of mental health services and other services where we have a shortage of available physician to provide in person care. Telehealth can allow physicians and others to extend their services to rural areas and to areas that otherwise may not receive the health care they need. If set up correctly, it can be very helpful in extending the reach and breadth of services that a Psychiatrist can give to individuals in rural areas in helping rural physicians care for the mental health needs of their patients. With a robust video conferencing system, a psychiatrist can diagnose a patient from many miles away. With a robust video conferencing system and the right technologies and diagnostic tools, a specialized surgeon or physician can help a rural physician perform more sophisticated surgery and diagnose more sophisticated diseases without the necessity of sending the patient to the urban setting or without sending that specialized physician to the rural setting and can help save lives and reduce costs. There are so many opportunities for the use of telehealth.

In addition to the sophisticated system of telehealth, the use of email, smart phones and devices, Internet and other technologies can be used in communication, monitoring and follow-up of patients. Use of these technologies can again reduce the need for in person visits thus reducing the cost of health care. No longer do patients always have to see a physician in person for follow-up care or go in to be monitored. By utilizing the technologies available, physicians can monitor diabetes, cardiac problems, other diseases and problems online or through reporting systems that automatically send the information from the monitoring device the patient has to the physician or the physician's office. Physicians can follow-up with patients via email and phone calls and through secure internet communication systems. Unfortunately, even though technology has expanded and is available to facilitate care and parts of care, many times physicians do not get paid for this type of care and so it is not utilized to the fullest extent possible. Often times patients must still travel in to see the physician because that is the only way the physician will be paid.

If we truly want to reduce health care costs and really want to maximize the use of available technologies and the number of physicians that are available to provide care then we need to redesign our payment system to reimburse for the use of these technologies in health care, both telehealth and telemedicine in the broadest sense of the word. That does not mean that this should be done without establishing laws, rules and regulations for the appropriate use of these technologies in health care.

Both the Federation of State Medical Boards (FSMB) and the American Medical Association (AMA) this year have come out with updated policies for the establishment and use of telehealth/telemedicine technologies when providing care in lieu of in-person care. These policies are very similar and the UMA supports both and would urge adopting them as we establish the basis of care via telehealth/telemedicine in Utah. We have attached a copy of both policies to this letter.

The key elements that we believe are necessary to establishing and using telehealth as an appropriate alternative to in-person health care are detailed in the attached policies but summarized below:

1. Establish laws, regulations, guidelines or protocols: Appropriate laws, regulations and guidelines or protocols should be established and enforced for the use of telehealth/telemedicine services. The health care services that are provided via telehealth should be set up in a way that protect patient safety and in no way decrease the quality of care received by a patient.
2. Consistent standards and scope: The standards and scope of the telehealth services should be consistent with related in-person services. The same standards of care and protocols established for use of telehealth services should have to be followed for all technologies used.
3. Physician-Patient relationship: A physician-patient relationship should be established. This includes establishing the mutual understanding that there is a shared responsibility for the patient's health care between the providers and the patient. The physician-patient relationship should be established either by the treating physician or the consulting physician (specifics set out in the AMA policies for establishing a valid patient-physician relationship).
4. State Licensure and Scope of Practice Laws: A physician providing care to a patient in the State of Utah must be licensed in the State of Utah regardless of whether or not they are located in Utah. They must be held to the standards, responsibilities and requirements of a licensee of Utah and they must be responsible to Utah for services rendered in compliance with Utah law.
5. Patient History and Documentation: A patient's medical history must be collected and documented before performing telehealth services. A patient must be evaluated either by the treating physician or the consulting physician and the relevant clinical history and diagnosis and underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment.
6. Informed Consent: Physician should receive Informed consent from the patient for treatment before rendering services.
7. Continuity of Care: Patients should be able to seek follow-up care or information from the treating physician and/or consulting physician and there must be care coordination with treating physicians. There must be protocols for emergency services referrals.
8. Privacy, Security and Transparency: Privacy, security and transparency protocols should be the same for telehealth as for traditional services – HIPAA compliant, etc.
9. Parity of Professional and Ethical Standards: Professional and ethical standards should be the same as when providing traditional health care.
10. Choice of Providers: Patient must have a choice of providers.

Again, thank you for allowing us to give input on this important subject. UMA believes we should move forward with telehealth in an aggressive but careful manner that contemplates the establishment of the correct protocols and procedures for telehealth and telemedicine in general and the establishment of recommendations for payment for providing telehealth and telemedicine services.

Again, we would urge using the attached 2014 AMA Telehealth Policies and Federation of State Medical Board Telehealth Policies in establishing Utah policies for telehealth/telemedicine in Utah.

Thank you for your time and efforts in this matter.

Michelle S. McOmber, MBA, CAE
Chief Executive Officer

Attachments

AMA Telemedicine Policy

Policy H-000.000 Coverage of and Payment for Telemedicine (number forthcoming)

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.

3. That our AMA encourage additional research to develop a stronger evidence base for telemedicine.

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.

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.

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.

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.

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.

(Council on Medical Services Report 7-A-14)

H-480.974 The Evolving Impact of Telemedicine

Our AMA:

(1) will evaluate relevant federal legislation related to telemedicine;

(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;

(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;

(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;

(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;

(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;

(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;

(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and

(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.

(CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13)

H-480.968 Telemedicine

The AMA:

(1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine;

(2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which 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.

(Res. 117, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: BOT Rep. 22, A-13)

H-480.969 The Promotion of Quality Telemedicine

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either

   (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or

   (ii) rendering of treatment to a patient within the board's state;

b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation;

c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and

d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.

(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties).

(CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed in lieu of Res. 920, I-13)

Updated June 2014

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

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.

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

[1] The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Model 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.

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;
- Adhere to recognized ethical codes governing the medical profession;

---

[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).

- 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

---

[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.

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.

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 by, 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:

---

[7] *See* Ctel.

[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.

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.

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 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;

[9] 45 C.F.R. § 160, 164 (2000).

- 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.

[END].

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.

SMART Workgroup

Kenneth B. Simons, MD, Chairman
Chair, State of Wisconsin Dept of Safety & Professional Services

Michael R. Arambula, MD, PharmD
Member, Texas Medical Board

Michael J. Arnold, MBA
Member, North Carolina Medical Board

Ronald R. Burns, DO
Chair, Florida Board of Osteopathic Medicine

Anna Earl, MD
Immediate Past President, Montana Board of Medical Examiners

Gregory B. Snyder, MD
President, Minnesota Board of Medical Practice

Jean Rawlings Sumner, MD
Past Chair & Current Medical Director, Georgia Composite Medical Board

Ex-Officios

Jon V. Thomas, MD, MBA
Chair, FSMB

Donald H. Polk, DO
Chair-elect, FSMB

Humayun J. Chaudhry, DO, MACP
President & CEO, FSMB

Subject Matter Experts

Elizabeth P. Hall
WellPoint, Inc.

Alexis S. Gilroy, JD
Jones Day LLP

Sherilyn Z. Pruitt, MPH
Director, HRSA Office for the Advancement of Telehealth

Roy Schoenberg, MD, PhD, MPH
President & CEO, American Well Systems

Staff Support

Lisa A. Robin, MLA
Chief Advocacy Officer, FSMB

Shiri Ahronovich, JD
State Legislative & Policy Manager, FSMB