PUBLICATION

Telemedicine Gains Further Acceptance [Ober|Kaler]

2016: Issue 11 - Focus on Fraud and Abuse

Last month the American Medical Association (AMA) adopted ethical guidance related to the practice of telemedicine and telehealth which further expands upon the policy report on Coverage and Payment for Telemedicine [PDF] it issued in June 2014, shortly after the Federation of State Medical Boards drafted its own model telemedicine guidelines.[1] (*For further discussion of the 2014 AMA report, see "AMA Issues Telemedicine Guidelines,"* Payment Matters *July 10, 2014.*)

Following that vein, the Centers for Medicare and Medicaid Services (CMS) has included expanded telehealth payment policies with its proposed CY 2017 Medicare Physician Fee Schedule.

This continuum of guidance illustrates the growing acceptance of telemedicine as a valid and needed model of medical service delivery. In addition, it communicates the need for additional flexibility in applying ordinary standards within the telemedicine and telehealth service delivery model.

AMA Guidance for Ethical Practice of Telemedicine

The AMA's 2016 guidance recognizes that telemedicine technologies will continue to emerge, even while the inherent challenges unique to telemedicine remain. For example, the AMA specifically highlights the risks to a patient's privacy and confidentiality that are further complicated with the introduction of third parties, such as telemedicine vendors. In addition, limitations inherent to electronic encounters present a significant challenge, as the absence of an in-person physical exam could create patient safety issues. Notwithstanding, the AMA suggests that emerging technologies that allow for alternate means of information collection have reduced the need for hands-on physical examination. On the other hand, electronic communication may hinder a specific patient interaction needed in certain situations. Just as communication skills are important in the "in-person" setting, the AMA asserts they are more so in telemedicine encounters. Therefore training physicians to effectively communicate in the telemedicine world should be a key part of the telemedicine delivery system. In consideration of these and other challenges, the AMA asserts that telemedicine is not a one-size-fits-all modality and appears to put the onus on physicians to determine its appropriateness. Where telemedicine is a suitable method of treatment, the AMA issued the guidelines below. These guidelines remind physicians that their fundamental ethical responsibilities do not change within telemedicine; further, a physician is tasked with understanding how those responsibilities may need to be applied, adhered to or executed differently.

- *Conflict of Interest*. Physicians must continue to put a patient's interests first. Disclosure of a potential conflict of interest, such as an ownership or other interest in a telemedicine vendor is important, as is the elimination or management of any such conflict.
- *Competency*. Physicians responding to and communicating with patients must have the appropriate credentials (license and education) and overall competence to address the specific issue, as dictated by state law and general practice standards. Within telemedicine, competence includes the ability to operate the telemedicine equipment and to explain the equipment to the patient, including its limitations. A physician's competence in this area will further include the physician's ability to determine whether or not telemedicine is an appropriate mode of care for a particular patient and how/when to shift to "in-person" modality when appropriate.

- *Disclosure and Informed Consent*. As suggested above, patients must receive appropriate information about the physician's competency and credentials as well as the capability and limitations of the telemedicine equipment and the telemedicine encounter. Patients must understand any additional burdens telemedicine may impose, e.g., a patient's surrogate may need to operate telemedicine equipment such as monitoring devices or cameras.
- *Privacy and Confidentiality*. As noted above, the risks to privacy and confidentiality are heightened within telemedicine, particularly when there are additional parties involved who have potential access to protected health information (PHI). Accordingly, not only must physicians ensure their privacy, security and confidentiality processes are in place, but they also must be "confident" that any third parties are similarly compliant with state and federal privacy and security laws. Physicians should alert patients of inherent privacy and security risks to data that is shared remotely and stored in more than one location.
- *Continuity of Care*. The obligation to ensure continuity of care is created when the physician-patient relationship forms, which the AMA suggests occurs when a physician responds to a specific health inquiry, rather than by providing general health information. Physicians should remind patients to maintain their information for future care, and offer to communicate directly with the patient's PCP if the patient prefers. If a physician is not certain whether the telemedicine encounter will be documented, for example when the telemedicine physician is part of a collaborative team, the physician should make his or her own encounter documentation.

In its conclusion, the AMA asserts that while telemedicine does have the promise of increasing access to care, it can only do so for those (patients and physicians) comfortable with and open to using the technology. The AMA cites the elderly, those with diminished capacities or those without access to the Internet, as examples of communities who may not easily adopt telemedicine. Accordingly, the AMA encourages the medical profession as a whole to engage in advocacy for making technologies more readily available and usable for those wanting to use telemedicine.

The AMA's recent telemedicine guidance is similar to past issuances by the AMA and FMSB in that it both highlighted the challenges of telemedicine as well as provided guidance for success. However, the 2016 guidance, rather than having a more cautious tone, seems to present the guidance in a more positive light by clearly conveying acceptance of telemedicine and highlighting its benefits now and in the future.

Expanded Telehealth Payment Policies

On July 7, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule [PDF] updating payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule on or after January 1, 2017. Among those proposals is the addition of several cost codes for services issued via telehealth. The codes include

- End-stage renal disease (ESRD) related services for dialysis
- Advance care planning services
- Critical care consultations furnished via telehealth using new Medicare G-codes

CMS is also proposing payment policies related to the use of a new place of service code specifically designed to report services furnished via telehealth.

[1] The Federation of State Medical Boards finalized its Interstate Medical Licensure Compact in September 2014.