

## Telemedicine and the Impediments Facing Effective Implementation

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### Introduction to Telemedicine

As the medical community continues to evolve to confront issues of health care cost, quality of care, and access to care, predicting what the practice of medicine will look like in the near future is almost impossible. In spite of this unpredictability, one aspect of health care delivery undoubtedly will be prominent—“telemedicine.”

The Federation of State Medical Boards defines the practice of telemedicine as 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.”<sup>1</sup> Although telemedicine technologies have existed for some time, recent rapid technological advancements have fostered an ever-growing demand for these services; such advancements have generated greater acceptance by medical professionals, greater public confidence in the use of computer technology, and higher standards in the communications, videoconferencing, and medical disciplines.

With these advancements, telemedicine is capable of not only drastically improving patients’ access to quality health care but also doing so at a low price. While evidence still is somewhat inconclusive regarding whether telemedicine leads to overall better patient outcomes, the present unsustainable growth in medical expenditures demands investment in new, more efficient health care delivery models such as telemedicine.<sup>2</sup> Before the full benefits of telemedicine can be realized, there are several hurdles impeding its implementation—primarily, legal issues ranging from privacy to malpractice liability. These hurdles arise as the relatively slow and complex lawmaking process attempts to keep pace with the technology industry where innovations can occur much more rapidly and introduce new sets of problems. To compound this issue, telemedicine requires coordination between both the states and the federal government.

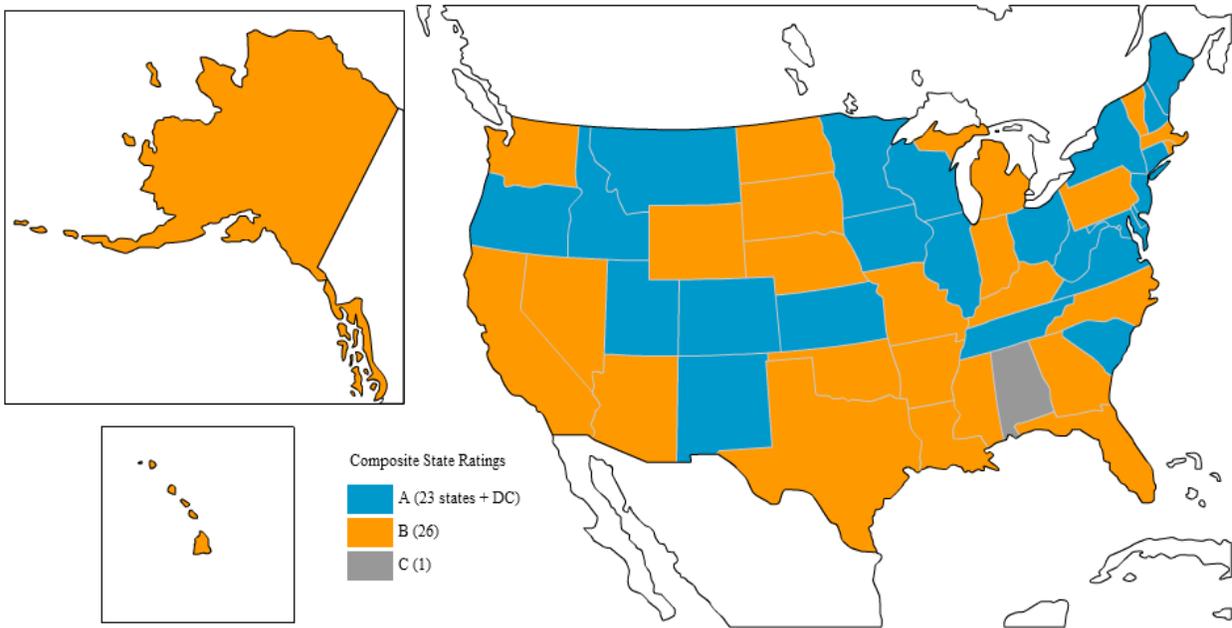
### How Is My State Faring?: Where Telemedicine Is Today

In a recent September 2014 publication, the American Telemedicine Association (ATA) compared the state laws and medical board standards addressing telemedicine for all 50 states and identified four specific indicators to determine whether states had a supportive policy landscape accommodating telemedicine adoption and usage, or whether certain states imposed barriers to telemedicine implementation and access.<sup>3</sup> The four indicators, to which each state was assigned an A, B, C, or F grade, are as follows: (1) *physician-patient encounter*, which reviewed the state information to determine whether telemedicine is permitted before, during, or after the physician-patient encounter; (2) *telepresenter*, which analyzed whether a telepresenter or health care provider must be on the premises during a telemedicine encounter; (3) *informed consent*, which considered whether written, verbal, or some unspecified method of informed consent is necessary before initiating the telemedicine encounter; and (4) *licensure and out-of-state practice*, which measured components of state medical board licensure requirements for out-of-state telemedicine providers, including reciprocity for bordering states, physician-to-physician consultation exemptions, and conditional/telemedicine licenses.<sup>4</sup>

ATA’s analysis highlighted that, while decades of evidence-based research have shown positive patient compliance, clinical outcomes, and increasing telemedicine usage, there has been a mix of strides and stagnation in state-based policy regarding telemedicine implementation.<sup>5</sup> Classifying the states into high, medium, and low scores shows 23 states and DC with the highest average scores, suggesting a climate that accommodates telemedicine adoption and usage; 27 states fell in the middle with room for improvement; and only one state (Alabama) had the lowest composite score, suggesting quite formidable barriers to telemedicine advancement.<sup>6</sup> The following map, excerpted from ATA’s recent Standards and Licensure survey, outlines this state-by-state comparison:<sup>7</sup>



Figure 1



ATA also has devoted its attention to another challenge hindering effective telemedicine implementation—coverage and reimbursement for services delivered by telemedicine.<sup>8</sup> In preparing its survey, ATA reviewed relevant state statutes, regulations, Medicaid program manuals, fee schedules, state employee handbooks, and other federal and state policy resources.<sup>9</sup> ATA reviewed 13 indicators related to coverage and reimbursement and found that the coverage and reimbursement arena likewise has lagged in both enabling and pioneering effective telemedicine reform. The 13 indicators related to coverage and reimbursement, which were similarly graded on an A–F scale, include the following: (1) *private insurance*; (2) *Medicaid*; (3) *state employee health plans*; (4) *patient setting*; (5) *eligible technologies*; (6) *distance or geography restrictions*; (7) *eligible providers*; (8) *physician-provided telemedicine services*; (9) *mental and behavioral health services*; (10) *rehabilitation services*; (11) *home health services*; (12) *informed consent*; and (13) *telepresenter*.<sup>10</sup> Each of these indicators represent categories where barriers to effective telemedicine implementation may exist. Nevertheless, where one state has adopted policies enhancing access to care, another state has adopted certain policies limiting the scope of telemedicine practice.

Overall, seven states earned the highest composite score, suggesting a supportive telemedicine payment environment, while three states averaged the lowest composite score, otherwise highlighting the existence of barriers to payment and little opportunity for telemedicine advancement.<sup>11</sup>

### Moving Forward—The Hurdles Facing Effective Telemedicine Implementation

As the most recent ATA surveys suggest, there are many hurdles facing effective telemedicine implementation. Three

particular challenges worth noting are highlighted below: portability of physician licensure; credentialing and privileges; and reimbursement.

#### Licensure

When a physician prescribes medicine or treats a patient, the physician is presumed to be practicing medicine where the patient is located.<sup>12</sup> The patient’s location is commonly referred to as the originating site; in contrast, the provider’s location often is referred to as the distant site. As ATA’s recent Coverage and Reimbursement survey noted:

[a] *traditional* approach to telemedicine coverage is to require that the patient be served from a specific type of health facility, such as a hospital or physician’s office. Left out by these approaches are the sites where people predominantly spend their time, such as homes, offices/place of work, schools, or travelling around.<sup>13</sup>

The traditional approach impedes effective telemedicine implementation by ignoring the practical and cost-effective advantages telemedicine has to offer. To increase patient access to care and reduce skyrocketing health care costs, less-costly solutions should be adopted that take advantage of telemedicine’s less-costly capabilities—as one article suggested, “deconstructing the traditional health care encounter.”<sup>14</sup>

Moreover, traditionally, physicians practicing within a state must obtain a full license to practice, with limited exceptions.<sup>15</sup> While some states have enacted medical licensure laws carving out exceptions for telemedicine practice,<sup>16</sup> this practice is not uniform. Nevertheless, the number of physicians and other health care providers practicing across state

# Physician Organizations

lines is only expected to increase; the contradiction, however, is that these same practitioners and providers operate in a traditional state-based approach to health care professional licensure.<sup>17</sup> The process for obtaining licensure to practice medicine varies from state to state and is dictated by each state's Medical Practice Act.<sup>18</sup> Each medical license may take upwards of two months, from the date of initial application to finally granting the license, and state licensing fees range from \$200–\$1,000.<sup>19</sup> Additionally, applicants for licensure must submit information that may affect their ability to practice, such as health status, malpractice actions/settlements, and criminal convictions.<sup>20</sup>

While multi-jurisdictional licensure poses certain obstacles for physicians, this piecemeal state-driven approach likewise prevents patients in neighboring states from receiving essential, often life-saving medical services available to neighbors directly across the state border.<sup>21</sup> A number of solutions have been proposed, including the possibility of implementing a federal or national licensure regime. While national licensure would disrupt the historically state-dominated realm of professional licensure, the state-by-state approach is incompatible with effective telemedicine implementation.

## Credentialing and Privileges

Additional impediments affecting telemedicine adoption are the current Centers for Medicare & Medicaid Services (CMS) rules regarding health care provider credentialing and privileging. As a condition of participation in Medicare, hospitals and critical access hospitals must require that all Medicare practitioners undergo credentialing and privileging by each originating site.<sup>22</sup> However, CMS has shifted towards a more telemedicine-friendly position and adopted a rule in the last four years that relaxes this credentialing and privilege requirement. Under this CMS Final Rule, when telemedicine services are provided at a distant-site hospital, the hospital whose patients receive the services may choose “to have its medical staff rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians and practitioner providing such services”<sup>23</sup> if four provisions are satisfied. This four-part test for providing telemedical services is as follows: (1) the distant-site hospital providing telemedicine services must be a Medicare-participating hospital; (2) the distant-site practitioner providing telemedicine services must be privileged at the distant-site hospital providing telemedicine services; (3) the distant-site practitioner must be licensed to practice medicine in the state in which the receiving hospital is located; and (4) the hospital whose patients are receiving the telemedicine services must have evidence of an internal review of the practitioner's performance, including, at a minimum, information on adverse events and complaints.<sup>24</sup> Without provisions allowing for services through origi-

nating- and distant-site providers, both the providing physician and the receiving hospital would be embroiled in the administrative complications of credentialing when implementing telemedicine services.<sup>25</sup>

## Reimbursement

Federal and state reimbursement laws governing coverage of telemedicine services further impede the use of telemedicine. Currently, Medicare pays for only a limited number of Part B services furnished by a physician or practitioner to a beneficiary via telemedicine.<sup>26</sup> Specifically, Medicare only covers telemedicine services offered to patients presented from an originating site.<sup>27</sup> Further complicating the issue, the originating site must be located in a county outside of a Metropolitan Statistical Area (MSA), a Health Professional Shortage Area located outside of an MSA, or in a rural census tract, as determined by the Office of Rural Health Policy within the Health Resources and Services Administration.<sup>28</sup> Finally, as a condition of payment, the provider must use an interactive audio and video telecommunications system that permits real-time communication between the provider, the distant site, and the beneficiary.

On the other hand, reimbursement for telemedicine services under Medicaid differs from state to state, and thus, suffers from the same disjointed approach to regulation as state professional licensure. With respect to Medicaid reimbursement of telemedicine services, states must still satisfy federal requirements of “efficiency, economy and quality of care.”<sup>29</sup> Once the state meets the necessary federal requirements, the state may choose: whether to cover telemedicine services; the types of telemedicine services that it will cover; how telemedicine will be provided and covered; and locations within the state where these services may be provided.<sup>30</sup> According to informal guidance issued by CMS on the Medicaid.gov website, Medicaid currently is encouraging states to use the flexibility “inherent in federal law” to create payment methodologies for services that use telemedicine technology.<sup>31</sup> Currently, 43 states have implemented provisions to cover telemedicine services in their Medicaid programs.<sup>32</sup> Some states also have required private insurance plans to cover telemedicine services, including 19 states and DC.<sup>33</sup>

Rather than expect reimbursement reform to precede widespread telemedicine adoption, it may be necessary for providers to initially finance telemedicine applications in an attempt to demonstrate the long term cost-savings benefits of the technology. As one article noted:

[i]t is unrealistic to expect a rapid return on investment for many telehealth applications. . . . Returns on investment should in general be considered a long-term matter. They will likely be achieved through reduced numbers of patients' visits to 'bricks and mortar' sites, increased sizes

of patient panels, and decreased numbers of high-cost events such as hospitalizations.<sup>34</sup>

Nevertheless, the reality is that the current framework scantily reimburses telemedicine services.

While telemedicine challenges traditional norms of what it means to “practice medicine,” health care is a service like any other on the market. Technological innovations in most other sectors of the economy have increased both convenience and consumer access to services—for example, automated teller machines, self-service gas stations, drive-through windows, and vending machines all are ways in which industry has adapted to more efficiently deliver goods to consumers.<sup>35</sup> Evidence suggests that health care consumers have similarly turned to the internet for answers to questions they traditionally might have received only during face-to-face office visits: “Among the 74 percent of US adults who use the Internet, 80 percent have searched online for information about health topics, 25-35 percent have read commentaries about health or medical issues, and 15-20 percent have found other people with similar health concerns.”<sup>36</sup> As telemedicine increasingly illustrates its practical benefits, perhaps reimbursement reform will follow suit.

## Conclusion

Although technological advancements offer the means to improve health care cost, quality, and convenience, legal impediments continue to slow telemedicine implementation. However, as these impediments are overcome, the medical practice landscape could see rapid and dramatic change. Medical practitioners must be ready to step outside their traditional practice methods, as patients expect their health care to keep pace with the many technological advancements pervasive in other aspects of their lives. Telemedicine could become the new traditional approach to medicine.

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1 FED. OF STATE MED. BDS., 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 (Apr. 2014), available at [www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB\\_Telemedicine\\_Policy.pdf](http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf).

2 Lee H. Schwamm, *Telehealth: Seven Strategies To Successfully Implement Disruptive Technology And Transform Health Care*, 33 HEALTH AFF. 200, 200 (2014).

3 LATOYA THOMAS & GARY CAPISTRANT, AM. TELEMED. ASS’N, STATE TELEMEDICINE GAPS ANALYSIS: PHYSICIAN PRACTICE STANDARDS & LICENSURE 4 (Sept. 2014).

4 *Id.* at 6-9.

5 *Id.* at 1.

6 *Id.* at 2-3 (tbl. 1).

7 *Id.* at 1 (fig. 1).

8 See generally LATOYA THOMAS & GARY CAPISTRANT, AM. TELEMED. ASS’N, STATE TELEMEDICINE GAPS ANALYSIS: COVERAGE & REIMBURSEMENT (Sept. 2014).

9 *Id.* at 4.

10 *Id.* at 6-22.

11 *Id.* at 1.

12 Amy E. Zilis, *The Doctor Will Skype You Now: How Changing Physician Licensure Requirements Would Clear the Way for Telemedicine to Achieve the Goals of the Affordable Care Act*, 2012 U. ILL. J.L. TECH. & POL’Y 193, 201-202 (2012) (citing MARY K. WAKEFIELD, HEALTH RES. & SERVS. ADMIN., HEALTH LICENSING BOARD REPORT TO CONGRESS 8, available at [www.hrsa.gov/ruralhealth/about/telehealth/licenserspt10.pdf](http://www.hrsa.gov/ruralhealth/about/telehealth/licenserspt10.pdf)).

13 See generally LATOYA THOMAS & GARY CAPISTRANT, AM. TELEMED. ASS’N, STATE TELEMEDICINE GAPS ANALYSIS: COVERAGE & REIMBURSEMENT 9 (Sept. 2014) (emphasis added).

14 Schwamm, *Telehealth: Seven Strategies*, *supra* note 2, at 202.

15 Zilis, *supra* note 12, at 193, 201.

16 FSMB, MODEL POLICY, *supra* note 1, at 11.

17 *Id.* at 1.

18 Zilis, *supra* note 12, at 193, 201.

19 *Id.*

20 FSMB, MODEL POLICY, *supra* note 1, at 6.

21 LATOYA THOMAS & GARY CAPISTRANT, AM. TELEMED. ASS’N, STATE TELEMEDICINE GAPS ANALYSIS: STANDARDS & LICENSURE 4 (Sept. 2014).

22 Gary L. Kaplan, *Legal Concerns in Specific Health Care Delivery Settings: Telemedicine and Telehealth*, 3 HEALTH L. PRAC. GUIDE § 46:13 (Am. Health Lawyers Ass’n 2014).

23 42 C.F.R. § 482.22(a)(3).

24 *Id.*; see also 42 C.F.R. § 485.616(2).

25 Greg Gillespie, *Will July 15 be a Dark Day for Telemedicine?* (Apr. 30, 2010), available at [www.healthdatamanagement.com/blogs/blog\\_Gillespie\\_telemedicine\\_privilege\\_by\\_proxy-40214-1.html](http://www.healthdatamanagement.com/blogs/blog_Gillespie_telemedicine_privilege_by_proxy-40214-1.html) (discussing possible harmful implications if CMS eliminates credentialing by proxy).

26 U.S. DEP’T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., TELEHEALTH SERVICES: RURAL HEALTH FACT SHEET SERIES 1 (2014), available at [www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfactsht.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfactsht.pdf) (hereinafter, U.S. DEP’T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., TELEHEALTH SERVICES: RURAL HEALTH).

27 Originating sites include offices of physicians or practitioners; hospitals; Critical Access Hospitals (CAHs); rural health clinics; federally qualified health centers; hospital-based or CAH-based renal dialysis centers (including satellites); skilled nursing facilities; and community mental health centers. *Id.* at 1-2.

28 Catherine Ho, *Current law restricts millions of Americans’ access to telehealth services*, WASH. POST (Oct. 19, 2014), available at [www.washingtonpost.com/business/capitalbusiness/current-law-restricts-millions-of-americans-access-to-telehealth-services/2014/10/17/4c529cc0-53c5-11e4-ba4b-f6333e2c0453\\_story.html](http://www.washingtonpost.com/business/capitalbusiness/current-law-restricts-millions-of-americans-access-to-telehealth-services/2014/10/17/4c529cc0-53c5-11e4-ba4b-f6333e2c0453_story.html); U.S. DEP’T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., TELEHEALTH SERVICES: RURAL HEALTH, *supra* note 26.

29 Medicaid.gov, *Telemedicine*, see [www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/telemedicine.html](http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/telemedicine.html).

30 *Id.*

31 *Id.*

32 NAT’L CONF. OF STATE LEGS., *State Coverage for Telehealth Services*, available at [www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx](http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx).

33 *Id.*

34 Schwamm, *Telehealth: Seven Strategies*, *supra* note 2, at 202.

35 *Id.* at 200.

36 *Id.* at 201.