Telemedicine: A Primer

By Andrew B. Wilson, Esq. Morris James LLP
Healthcare has never been more expensive than it is today. The Centers for Medicare & Medicaid Services reported at the end of 2018 that health care spending is now about 17.9% of the nation’s Gross Domestic Product and had reached $10,739 per person in 2017. Individuals, families, businesses, and state and federal budgets are feeling the pinch as these costs trend up. Under immense pressure, the delivery system is shifting from fee-for-service to fee-for-value. Simply put, no longer paying or being paid for an individual service, but instead measured for the quality of the service delivered. By way of example, bundled and capitated payments paired with upside and downside risk. All of it based on data measurement and interoperability like never seen before. The emphasis is predicted to be on advancing the care of the individual and of the population health to make a healthier country and thus a less costly country. In this context, the future of telemedicine is bright, nearly-certainly destined to be ubiquitous.
The market predictions seem to support this assertion. While the numbers are as various as the definitions we’ll discuss in more detail, all signs point to telemedicine – often used interchangeably with “telehealth”– as a massive and growing market. As reported in Forbes by Quora in July 2018, “global telemedicine will be worth more than $66 billion by the end of the year 2021”. A more conservative estimate by MarketWatch in August 2018 predicts a domestic $9.5 billion market by 2022. This is a meteoric rise as Accenture predicted a billion dollar industry by 2018 in just 2016.

Intuitively, this makes sense. As technology-savvy populations grow from “invincible” years into larger consumers of health care, for themselves and for their children, it makes sense that the supply will follow the demand. What it will do our delivery systems is yet to be seen. Arguably, the largest question on the horizon being at what point does telemedicine, substantially reaching its maturation outside of the current delivery system, reach critical mass and be more—largely adopted inside of existing continuity of care models. As we’ll discuss more, there are numerous growing pains for telemedicine to reach its potential.
Telemedicine means a lot of things to a lot of different stakeholders in the broader healthcare industry. For most, what is consistent is a feeling of “otherness.” That is, that telemedicine is something that is separate and apart from the current experience of a patient visiting a clinic, practice, or emergency department and sitting in the same room with the treating clinician. However, telemedicine is not new by any stretch.

Let’s start with the most basic of definitions. Telemedicine is the remote diagnosis and treatment of patients by means of telecommunications technology. In fact, if we dig into the etymological roots of the word itself “tele” simply means distant in Greek. “Telephone” being roughly “distant voice.” “Teledactyl,” a 1925 futuristic prediction of telemedicine by Hugo Gernsback, the namesake for the science fiction Hugo Awards, adds in “dactyl” which means “finger.” In Gernsback’s own words in Science and Invention:

*The Teledactyl (Tele, far; Dactyl, finger — from the Greek)* *is a future instrument by which it will be possible for us to “feel at a distance.” This idea is not at all impossible, for the instrument can be built today with means available right now. It is simply the well known telautograph, translated into radio terms, with additional refinements. The doctor of the future, by means of this instrument, will be able to feel his patient, as it were, at a distance ... The doctor manipulates his controls, which are then manipulated at the patient’s room in exactly the same manner. The doctor sees what is going on in the patient’s room by means of a television screen.*

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In the age of the house call, his additional predictions were also quite salient:

*The busy doctor, fifty years hence, will not be able to visit his patients as he does now. It takes too much time, and he can only, at best, see a limited number today. Whereas the services of a really big doctor are so important that he should never have to leave his office; on the other hand, his patients cannot always come to him. This is where the teledactyl and diagnosis by radio comes in.*

Of course, this isn’t fiction now. However, even before the advent of the smart phone and wearable technology, stunning examples of telemedicine can be found everywhere. Dramatically, the vitals of the astronauts were relayed to Houston during the moon landing in 1969. More pedestrian, patients have called their doctors to describe everything from sniffles to post-surgery complications since essentially the invention of the telephone.

Many payers still require “distance” before reimbursing for a telemedicine visit. Others are embracing that “distance” can be far more than a measure of geography and more a function of “barriers” that can be overcome through technology. Difficulty in travel can be a barrier. Pain in movement can be a barrier. Mental illness that makes treatment outside of familiar spaces can be a barrier. Living a busy lifestyle that leads to deferred care can be a barrier. What is key is that the patient and the clinician are being connected through technology, most commonly a synchronous video chat using a computer or smart phone.
Can I practice telemedicine in my state?

It depends, but almost certainly in some form or fashion. The telemedicine landscape is a patchwork between the states with even the very definition of telemedicine having differences across the state boundaries. For instance, must there must be a video connection? Must it be real-time? Must the patient be at a specific and qualified originating site? Some state boards of medical licensure have even considered outright de facto bans on telemedicine such as a requirement for an in-person visit before its use, but most have stopped short after bellwether anti-trust lawsuits. However, most states have enabling statutes that create clear pathways for the practice of telemedicine.

Can I bill for telemedicine?

A growing number of states have passed payment parity laws which require many, but not all, insurers to pay for services delivered over telemedicine at the same rate as they would if the service was delivered in-person. However, even in the states where these laws are passed, not every payer will be covered by these laws. Medicare as a federal program cannot be directed by state laws. Similarly, large employers are often covered by ERISA, another federal statute which prevents state laws from adding state-by-state requirements to employer benefits like health insurance. Medicaid will have program-specific requirements state-by-state.

In this landscape, there has been a proliferation of direct-to-consumer companies that sit outside of insurance programs and deliver episodic, cash-based services. In a model not dissimilar from popular ridesharing platforms, the clinicians that contract with these companies will “flip on” their service light and see patients akin to a virtual walk-in clinic. There are hybrid models as well that offer a cash option, but still take insurance.
Can I practice my medicine using telemedicine?

Yes, but the applicable standard of care does not change between an in-person visit and a telemedicine visit. The basic threshold question any practitioner should ask themselves is “if this patient was sitting in front of me, could I make this diagnosis or deliver this service?” If there is a deviation from reasonable care that results in harm to the patient, it’s not a defense that it was through a telemedicine encounter, barring extenuating circumstances.

Setting that aside, even if your medicine cannot yet be delivered (yet) via telemedicine, for instance an extreme example like a surgery, there are portions of a visit that can be completed via telemedicine, such as a patient history that can help with practice efficiencies for the patient visit.

Importantly, it can also help with hand-offs as the patient moves between settings. If you practice primary care, telemedicine can bring a specialist to the patient in the same visit, facilitating adherence to a care plan. The other side of the coin is that specialists like psychiatrists can integrate their services readily into the primary care model using telemedicine.

There are also hybrid models that use fixed kiosks in malls, grocery stores, or other populated centers that patients visit and the clinician appears to them virtually. Some even have a medical assistant present and have a heavy use of peripherals to augment the data available to the remotely-located clinician.
What licensing do I need? Can I deliver telemedicine while I’m on vacation in another state?

Barring some potential nuances in the Veterans’ Affairs system, the medicine originates with the patient, not with the clinician. Therefore, to deliver medicine to a patient, you must be licensed where the patient is located. Absent a potential corresponding obligation, most likely through contract, to be accessible to the patient in some amount of time, there are few limitations on where the clinician is located so long as they are licensed where the patient is located. That’s why a best practice for telemedicine is to ask and document where the patient reports they are located before delivering a service.

Should I or my patients be worried about privacy?

All of the same patient information protections like HIPAA, as amended by HITECH, still apply to a telemedicine setting. Practitioners should be wary of their setting and their patient’s setting when delivering a service to protect patient confidentiality. Best practices around the use of secured internet connections should also be consistently applied and adhered to. With the proliferation of electronic medical records and e-prescribing, most practices undergo some level of a cyber security audit and that can extend to a practice’s telemedicine platform as well.
Can I prescribe using telemedicine?

Online and internet prescribing is often regulated separately than traditional prescribing, with added layers of protection like secondary validation and limitations on controlled substances. Many states outright ban controlled substance prescribing through the internet. A major practical limitation for some models of telemedicine is that both prescribing and dispensing flow through a licensee like a physician and pharmacist. The most common help in a telemedicine program with an in-person component is a medical assistant, who is unable to provide the patient even basic pharmaceuticals in most states. However, through most clinicians’ licenses, prescribing can occur as it would in-person.

Does all telemedicine have to be live encounters?

No. In fact, Medicare in 2018 proposed a new definition to expand payment for remote patient monitoring services. Broadly, remote patient monitoring is the remote collection of data that the patient either inputs manually or it can be collected passively. That data is used for clinical flags, such as high blood sugar, low blood pressure, increased pulse, a sudden spike or drop in weight, even whether or not a pill case or nebulizer has been used. That patient monitoring can be used to ensure patient safety, patient wellbeing, and treatment adherence.
**Business Plan** – While the virtues and economics of a telemedicine infrastructure, or at least arrangement, in a value-based payment structure are clear, most practices still operate mostly in a fee-for-service model. Inside of this model, practices should survey their payer mix, take a look at the states’ laws, factor in where, if anywhere, cash can play a role, and then simply do the math. Even in states with low or no payment, are there efficiencies that can be found for patient intake, handoff, discharge, or ongoing monitoring? Likely, yes.

**Technology** – Many practices still operate under the misconception that there is a costly technology investment to start to use telemedicine. There was a brief period in time where $20,000 telemedicine carts seemed to proliferate in hospitals and big practices. Five years later, it’s often no fancier than a tablet on wheels or a simple computer with a built-in camera and a quiet room. Software vendors abound with access to platforms with many bells and whistles in the hundreds of dollars, not thousands.

**Licensing** – While the Federal of State Medical Boards (FSMB) interstate compact is growing, which will streamline the licensing process for practices seeking to grow their reach outside of their home states, that merely adds an efficiency to the licensing process. Some states have episodic or consultative care pathways and others have special telemedicine licensure. The strongest foundation for a program is licensure where the patient is located.

**Contracts & Insurance** – While not an exhaustive list, depending on the practice type and patient mix, there are a few initial best practice steps. Steps that are likely overdue in your practice to begin with, even without telemedicine. Consult with your malpractice carrier to audit your coverage. Be sure your Business Associate Agreements are reviewed and in place. Do a HIPAA check-up to ensure standards and protocols are in place. Consider a cyber security audit to test for weaknesses and access to patient data. In our connected world, even if your practice does not do telemedicine, these are easily-overlooked best practices.
Practices that have been early adopters of telemedicine have already reaped economic benefits. They are also best-poised to rapidly expand their infrastructure to meet the demands and measurements of the coming value-based system. By creating easy pathways to access, fostering a telemedicine-friendly staff culture, or fostering good patient habits and adherence in remote patient monitoring programs, practices have seen better patient outcomes and seen better payments for their services.

It’s not without its downsides and frustrations, of course. Most practices have difficulty with real-time patient insurance eligibility; hunting down reimbursement can induce hair-pulling for any practice already thrumming with patients. The payment hassles have deterred many from full implementation, understandably.

But start small. Telemedicine comes in all shapes and sizes and in no setting is telemedicine stronger than inside of an existing clinician-patient relationship.

About the Author

Andrew B. Wilson (“Drew”) is an attorney and legislative specialist in Morris James LLP’s Health Care Industry and Government Relations Groups. Mr. Wilson assists clinicians and their practices through licensing questions, how to expand their business and billing, and regulatory compliance. Mr. Wilson started his career as counsel in the New York State Senate. He was counsel to four Senators as well as the Alcoholism & Drug Abuse Committee. In addition to building an expertise in health law and policy, Mr. Wilson has worked on many political campaigns ranging from volunteer to kitchen cabinet to statewide campaign manager where he has built an expertise in campaign and election law. He’s been voted a top healthcare attorney by his peers in the Delaware bar and received the “40 under 40” distinction from Delaware Business Times. He is a board member of the Delaware Center for Health Innovation, an organization comprised of the top health care leaders of Delaware. He received his B.A. degree from St. Lawrence University and his J.D. degree from Albany Law School. Mr. Wilson is a member of the American Bar Association, the American Society of Medical Association Counsel, and the Delaware State Bar Association where he co-chairs the Health Law section.

5 https://www.smithsonianmag.com/history/telemedicine-predicted-in-1925-124140942/
6 Id.
7 See, e.g., Teladoc v. Texas Medical Board
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