Position Statement on Telemedicine

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Telemedicine is a rapidly growing method of care delivery. The Academy supports the use of telemedicine to deliver dermatologic expertise to populations who would not otherwise have access to dermatologists. Practitioners who wish to integrate teledermatology into their practice will likely choose between two fundamentally different care delivery platforms (Store and Forward vs. Live Interactive). Both platforms have strengths and weaknesses. What follows is a definition of each platform and the respective AADA position.

I. LIVE INTERACTIVE TELEDERMATOLOGY

a. Definition

Live interactive teledermatology takes advantage of videoconferencing as its core technology. Participants are separated by distance, but interactive in time. In 2004, due to bandwidth and equipment expense constraints, most live and interactive teledermatology takes place between institutions, such as hospitals and clinics. By convention, the site where the patient is located is referred to as the *originating site* and the site where the consultant is located is referred to as the *distant site*. A high resolution camera is required at the originating site. Videoconferencing systems work optimally when a connection speed of 384 kbps is used. Slower connection speeds may necessitate that the individual presenting the patient perform either still image capture or freeze frame to render a diagnostic image. For most diagnostic images, a minimum resolution of 800 x 600 pixels (480,000) is required.

b. Credentialing and Privileging

The Joint Commission for Accreditation of Health Care Organizations (JCAHO) has adopted standards for telemedicine. Practitioners who render care using live/interactive systems are subject to credentialing and privileging at the distant site when they are providing direct care to the patient. The originating site may use the credentialing and privileging information from the distant site if all the following requirements are met: (i) the distant site is JCAHO-accredited; (ii) the practitioner is privileged at the distant site for those services that are provided at the originating site, and the originating site has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site

information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance management.

c. Medical Records

Appropriate medical records should be available to the consulting dermatologist prior to or at the time of the telemedicine encounter. This information should include specific questions requested by the referring physician.

A copy of the record generated by the telemedicine consultation should be subsequently available at both the consultant and the referral sites. These records should be maintained according to the policies of each site.

d. Privacy and Confidentiality

Practitioners who practice telemedicine should insure compliance with the Health Insurance Portability and Accountability Act (HIPAA). (While video or store and forward transmissions over ISDN infrastructure are thought to be secure,) IP transmissions should be encrypted when running over the public internet. IP encryption in other cases (e.g., private or semi-private networks) is recommended. The handling of records, faxes, and communications is not different from a standard office environment.

e. Licensing

Interactive telemedicine requires the equivalent of direct patient contact. In the U.S., teledermatology using interactive technologies is restricted to jurisdictions where the provider is licensed.

f. Reimbursement

Medicare reimburses for evaluation and management codes and consultation codes for office visits and consultations billed for patients located in non-metropolitan statistical areas (non-MSAs). This includes nearly all rural counties. A definition and listing of qualified areas is available at *http://www.cms.hhs.gov/manuals/pm_trans/R1798B3.pdf*. In some states, Medicaid reimburses as well, but many have restrictions. Private insurers vary in their policies, but most will reimburse services provided to patients in rural areas. It is recommended that the provider write a letter of intent to the insurer informing them that the provider will be billing for telemedicine services. A model letter of intent can be found at *http://www.aadassociation.org*.

g. Liability

If a direct patient care model (provider to patient) is used (no provider at the referring site), the liability rests entirely on the dermatologist. The diagnostic and therapeutic recommendations rendered are based solely on information provided. Therefore, the liability should be based on the information available at the time the consult was answered.

II. STORE AND FORWARD TELEDERMATOLOGY

a. Definition

Store and forward teledermatology refers to a method of providing diagnostic advice, usually to another provider. A dermatologic history and a set of images are collected at the point of care and transmitted for review by the dermatologist.

In turn, the dermatologist provides a consultative report back to the point of care. A consumer-grade digital camera with a minimum of 800 x 600 pixel (480,000) resolution is recommended. For systems that transmit over the Internet, a minimum 128-bit encryption and password level authentication are recommended.

b. Credentialing and Privileging

The Joint Commission for Accreditation of Health Care Organizations (JCAHO) has adopted standards for telemedicine. Practitioners who render care using store and forward systems are viewed by JCAHO as “consultants” and are not required to be credentialed at the originating site as of 1 January 2004 (see JCAHO MS 4.120.)

c. Medical Records

Most store and forward systems work as de-facto electronic medical records. The record of the care is typically available electronically to both the consultant and the referring provider.

d. Privacy and Confidentiality

In this case, HIPAA compliance is largely a matter of letting patients know that their information will be traveling by electronic means to another site for consultation. This should be noted in the consent form at the point of care. In addition, all electronic transmissions should be encrypted and reasonable care should be taken to authenticate those providers who have electronic access to the records.

e. Licensing

Most states will permit a physician licensed in another state to act as a consultant to a locally licensed doctor as long as responsibility for the care and treatment of the patient is not transferred to the remote consulting physician. Providers who wish to provide store and forward consultations across state lines should be aware of the licensing laws and regulations for the states in which they wish to provide care.

f. Internet Prescribing

Store and forward providers should take care regarding direct prescribing for patients via electronic communications. Most states have regulations that discourage or prohibit practitioners from prescribing for patients that they have not seen face to face. In many cases, the wording of these regulations is such that a live and interactive consultation would meet the requirements for a “face to face exam”. Since most store and forward providers are working in collaboration with a provider at the point of care, this should not inhibit patient care. The dermatologist should take care to recommend as opposed to prescribe.

g. Reimbursement

Store and forward teledermatology is being reimbursed by CMS only as a demonstration project in Hawaii and Alaska. However, South Dakota and Minnesota are currently reimbursing store and forward teledermatology for Medicaid patients. There are also private insurers that are paying both live interactive and store and forward modalities. Providers who wish to provide store and forward services should inquire with their commercial payers regarding reimbursement.

h. Liability

In the consultative mode (provider to provider), the referring provider ultimately manages the patient with the aid of the recommendations from the consultant. The referring provider may accept the recommendations in part or whole or none at all, and the liability in this scenario will be shared (between the referring provider and the consultant) based on the extent to which the recommendations were followed by the referring provider.

i. Training and Quality Assurance

It is recommended that organizations participating in teledermatology have an active training and quality assurance program for both the distant and receiving sites. It is recommended that those programs, which are using teledermatology, have documentation of their training program for the consult manager or technician who is doing the image capture and managing the consults. It is further recommended that each organization should maintain documentation on how the program promotes high quality of the clinical and image data.