American Academy of Dermatology and AAD Association
Physicians Dedicated to Excellence in Dermatology™
Position Statements

Position Statement on Telemedicine
(Approved by the Board of Directors February 22, 2002
Amended by the Board of Directors May 22, 2004
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Telemedicine is a rapidly growing method of care delivery. The Academy supports telemedicine as a means of improving access to expertise of Board certified dermatologist and increasing safety, in addition to encouraging professionalism through patient care coordination and communication between other specialties and dermatology. Practitioners who wish to integrate teledermatology into their practice should have a good understanding of the culture and other characteristics of the site from which consults are originating. Telemedicine encounters are appropriate for new and established patients, in order to maximize access. Optimally, appropriate in-person follow-up should be available; this will help ensure the patient experiences the safest, highest quality, and best-valued dermatologic care available in their setting.

Teledermatology providers choose between or combine two fundamentally different care delivery platforms (Store-and-Forward vs. Live Interactive,) both of which have strengths and weaknesses. What follows is a definition of each platform and the respective AADA position on each.

I. LIVE INTERACTIVE TELEDERMATOLOGY

a. Definition
Live interactive teledermatology takes advantage of videoconferencing as its core technology. Participants are separated by distance, but interact in real time. 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. A monitor with resolution matched to the camera resolution is required at the distant 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 quality image. For most diagnostic images, a minimum resolution of 800 x 600 pixels (480,000) is required. As with most telecommunication systems advancements, maximal resolution increases diagnostic fidelity.

b. Credentialing and Privileging
The Joint Commission (TJC) has implemented standards for telemedicine. Under the TJC telemedicine standards, 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 TJC-accredited; (ii) the practitioner is privileged at the distant site for those services that are provided at the originating site; and (iii) 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 the respective locations.

d. Privacy and Confidentiality
Practitioners who practice telemedicine should ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, and it's implementing regulations. While video or store-and-forward transmissions over ISDN infrastructure are thought to be secure, IP transmissions should be encrypted when transmitted over the public internet to ensure security. IP encryption in other settings such as private or semi-private networks is also highly recommended. The handling of records, faxes, and communications is subject to the same HIPAA standards as apply in 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 permitted, by law, to practice. In other words, the provider using interactive technologies usually must be licensed to practice medicine in the jurisdiction where the patient is located.

f. Reimbursement
Medicare reimburses for consultations, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system 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 via U.S. Census data at http://www.census.gov/population/metro. However, there is no limitation on the location of the health professional delivering the medical service. In some states, Medicaid reimburses for telemedicine services 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. For the latest reimbursement information, see the American Telemedicine Association or CMS websites.

g. Responsibility/ Liability
If a direct-patient-care-model (provider to patient) is used (no provider at the referring site), the consulting dermatologist bears full responsibility (and potential liability) for the patient's care. The diagnostic and therapeutic recommendations rendered are based solely on information provided by the patient. Therefore, any liability should be based on the information available at the time the consult was answered. In a consultative model (provide to provider), liability may be shared; however, the allocation of responsibilities will vary on a case-by case and state-by state basis.

II. STORE-AND-FORWARD TELEDERMATOLOGY

a. Definition

Store-and-forward teledermatology refers to a method of providing consultations to referring providers or patients, rather than direct, interactive care to patients. 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 referring provider at the point of care. In this modality, participants are separated by distance and time. A digital camera, whether integrated in a mobile handheld device or comprehensive telecommunications system or a stand-alone product, with a minimum of 800 x 600 pixel (480,000) resolution is required; however, higher resolutions may increase diagnostic fidelity. For systems that transmit over the Internet, a minimum 128-bit encryption and password-level authentication are recommended.

b. Credentialing and Privileging
Practitioners who render care using store-and-forward systems are viewed by TJC as "consultants" and may not be required to be credentialed at the originating site. However, standards can vary by state and organization.

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 consulting and the referring provider.

d. Privacy and Confidentiality
In this case, HIPAA compliance is largely a matter of the originating site 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, and the HIPAA notice of privacy practices. 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 require the physician to be licensed in the same state as where the patient resides, even when he or she acts only as a consultant Providers who wish to provide store-and-forward consultations across state lines should limit such consultations to originating states in which they are permitted, by law, to provide care.

f. Internet Prescribing
Store-and-forward providers should exercise caution 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." The Federation of State Medical Boards established a National Clearinghouse on Internet Prescribing located at http://www.fsmb.org/ncip_overview.html. The Clearinghouse includes a state-by-state breakdown of jurisdiction, regulations, and actions related to the regulation of Internet prescribing. Since most store-and-forward providers are working in collaboration with a provider at the point of care, it should not be necessary for the consulting dermatologists to write prescriptions for the patient. Dermatologists providing direct-to-patient care, including directly prescribing medications or placing orders for the patients, need to make every effort to collect accurate, complete, and quality clinical information. When appropriate, the dermatologist may wish to contact the primary care

providers to obtain additional corroborating information. In addition, as with all forms of teledermatology, dermatologists directly prescribing medications to patients need to be fully aware of the medical-legal considerations governing such practice.

g. Reimbursement
As of 2013, CMS reimburses store-and-forward teledermatology only as a demonstration project in Hawaii and Alaska. However, Alaska, Arizona, California, Illinois, Minnesota, Oklahoma and South Dakota are currently reimbursing store- and-forward teledermatology for Medicaid patients. There are also private insurers that are paying for both live interactive and store and forward modalities, including those that are part of a Medicare Advantage plan. Providers who wish to provide store-and-forward services should inquire with their commercial payers regarding reimbursement.

h. Liability
In the consultative model (provider to provider), the referring provider ultimately manages the patient with the aid of the consultant's recommendations. The referring provider may accept the recommendations in part or whole or none at all, and the responsibility and potential 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. As noted above, if a direct-patient-care model (provider to patient) is used (no provider at the referring site), the responsibility and potential liability rests entirely on the teledermatologist.

i. Training and Quality Assurance
Organizations participating in teledermatology should have an active training and quality assurance program for both the distant and receiving sites. In addition, those programs that are using teledermatology, should have documentation of their training program for the consult manager or technician who is capturing clinical images and managing the consults. Each organization should also maintain documentation on how the program promotes high quality clinical and image data, continuity of care and care coordination for patients who may require additional in-person evaluations and procedures. Finally, organizations should review the American Telemedicine Association's Practice Guidelines for Teledermatology, as well as its Quick Guide to Store-and-Forward and Live-Interactive Teledermatology for Referring Providers.

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