Regulatory Perspectives on Telephone-Based Cross-Coverage: Principles for Decision-makers

Spotlight: Ideal Telehealth Consultation Service

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About the Authors

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Mr. McMenamin was a university-trained internist and a practicing emergency physician before being admitted to the bar. He holds medical (1978) and law (1985) degrees from the University of Pennsylvania and served a straight medicine residency (1978-1981) at Emory University and Grady Memorial Hospital in Atlanta before joining McGuireWoods in 1985.

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He has lectured and written extensively on domestic and international medical-legal topics. Audiences have included the American Bar Association, American Telemedicine Association, American Heart Association, Triangle Healthcare Executives Forum, International Bar Association, and the American Society of Law, Medicine & Ethics.

Authored books include: Navigating the Legal Maze of Telemedicine (with Barry B. Cepelewicz, M.D., J.D.) and Using the Internet for Healthcare Information: Legal Issues, and Legal Aspects of Developing and Implementing Clinical Practice Guidelines. Additionally, Schanz served as legal columnist for Telemedicine Today magazine. He currently serves as a Teaching Assistant Professor in the College of Management at North Carolina State University where he teaches in the BioSciences Management MBA program.
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He frequently speaks at seminars on topics related to health care regulatory issues and health care litigation, and he has recently written several articles on health care legal issues, including, *A Closer Look at Telemedicine's Legal Issues* (HHN Most Wired Magazine, April 30, 2008) and *Could Your Doctor Be Prohibited from Treating You?* (Indianapolis Business Journal, April 14-20, 2008).
Regulatory Perspectives on Telephone-Based Cross-Coverage: Principles for Decision-makers

Introduction

Telemedicine is defined by the American Telemedicine Association (ATA) as, “the use of medical information exchanged from one site to another via electronic communications to improve patients’ health status. Closely associated with telemedicine is the term "telehealth," which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services.”¹

From the perspective of the primary care physician, this broad definition is notable because it rightfully includes practice via telephone. From a clinical perspective, telephone practice and more advanced forms of telemedicine are aligned because a required competency for both is the ability to judge whether available information is sufficient for diagnosis and management. As in telephone practice, the need to refer to a traditional, in-person care setting for hands-on, laboratory, or imaging evaluation, or some combination of these approaches, is always a consideration. Experience with telephone practice provides valuable preparation for meeting the demands of other forms of telemedicine.² Today, telehealth and related technologies are making healthcare easier to access, more precise and accurate.

Telephone-based cross coverage evolved as a means of providing physicians a resource for serving patients when they are not available, either after-hours, on weekends or during vacation periods. As physicians go off duty, they provide information to a “cross-covering” physician who will care for patients in the interim,³ with the process often referred to as “taking call.” Traditionally, these arrangements did not usually involve the sharing of patient charts since doing so physically would be very difficult, and not all doctors use an EHR.⁴

This often means that covering physicians know little or nothing of the patient’s previous illnesses or medical conditions, current medications, allergies and other important data, making it more difficult to make an accurate diagnosis and recommend appropriate treatment or prescriptions.

² McConnochie, Kenneth M, MD, MPH; Potential of Telemedicine in Pediatric Primary Care; Pediatr Rev. 2006 Sep;27(9):e58-65; American Academy of Pediatrics
⁴ Ferris, Nancy; 4 percent of U.S. doctors use EHRs, new study finds; Government Health IT; June 18, 2008; http://govhealthit.com/Articles/2008/06/4-percent-of-US-doctors-use-EHRs-new-study-finds.aspx; Accessed 2/19/09.
The modern telephone cross-coverage model allows physicians to “cover” for one another via the telephone on a round-the-clock basis and have an electronic health record at their fingertips. It also facilitates access to primary care, even in physician-underserved areas.

This document examines the potential for telephone-based cross-coverage, specifically physician telephone consults. Many companies appear to offer such services, including TelaDoc Medical Services (www.teladoc.com), American Well (www.americanwell.com), Consult a Doctor (www.consultadoctor.com) and Call MD (www.callmd.com). Their aim is to deliver a practical, easy-to-implement and cost-effective solution to individuals wherever they are located. The legal issues and perspectives provided in this paper are intended to be useful to lawmakers, regulators, government officials and others who require credible information for guiding their decisions regarding telehealth programs.

As technology evolves and more advanced equipment becomes available, telephone-based cross-coverage, as understood today, may become a part of the expected, de facto standard for healthcare delivery.

Absent such programs, healthcare enterprises may find that their delivery systems fall short of meeting market expectations for a complete range of services. This could pose some legal issues if consumers perceive a gap in care that could have been addressed by this technology and a specific patient outcome that was less than it could have been for want of access to service of this kind.

There are ample legal precedents regarding minimum requirements for healthcare. One of the most litigated stems from a provision in federal law that imposes liability upon government for the deliberate indifference of the healthcare needs of prisoners.5 In relevant part, the Estelle court said:

The indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner’s serious illness or injury states a cause of action under § 1983.

Courts have also held that the regulations delineating the use of emergency medical equipment do not bar the airlines from providing supplemental equipment and do not preempt regulation of the field. Although the regulations do prescribe items that airlines are obliged to include in emergency medical kits, they merely set forth minimum requirements. By definition, minimum requirements permit and authorize the party to whom they apply to exceed the minimum. Thus, the emergency medical kit regulations themselves do not bar the airline from carrying supplemental devices to protect its passengers, or state law from requiring more of airlines.6


Overview of Telephone-Based Cross Coverage

Rapid telephonic consultation with an easily accessible practicing physician can help a patient seek appropriate care for particular medical problems. Often, patients turn to the emergency department (ED) simply because they have no alternative source for medical care. Telephone-based cross-coverage services address the problem of disturbing increases in waiting times at emergency rooms nationwide, most recently documented by an analysis by researchers at the Cambridge Health Alliance and Harvard Medical School. They found that the median waiting time to see a physician in hospital emergency departments jumped from 22 minutes in 1997 to 30 minutes in 2004. Telephonic medical consults can and do provide access to highly skilled physicians 24 hours a day, seven days a week.

One of the most promising applications of telephone-based cross-coverage solutions is in rural communities where residents face a unique combination of factors that create disparities in healthcare not found in urban areas. Economic factors, cultural and social differences, educational shortcomings and the sheer isolation of living in remote rural areas all contribute to impediments to rural Americans seeking to lead normal, healthy lives. These communities also suffer from inattention to these obstacles by their state and federal legislators.

Telephone-based cross-coverage programs are tearing down previously formidable barriers to accessing quality healthcare. Telephone medical consults conducted by experienced primary care physicians appropriately address routine, acute, non-emergent, non-recurrent medical conditions. Experience has determined that there are about 550 clinical scenarios suitable for telephonic consultations; 120 of these scenarios may be appropriate for intervention by a physician instead of or in addition to that of a nurse. Some examples include such common clinical problems as:

- Respiratory infections
- Gastroenteritis
- Sinusitis
- Bronchitis
- Urinary tract infections
- Pharyngitis
- Seasonal allergies
- Prescription refills as appropriate

Today, telephone-based cross-coverage programs have also become extremely helpful in tackling specific issues related to chronic care management. This is one of the most encouraging applications of telephone-based cross-coverage since individuals with chronic disease such as diabetes, cancer, or heart disease are the most likely to experience adverse health consequences as a result of disruptions in access to medical care. A key decision facing the physician caring for such patients is whether the nature of the problem allows responsible decision-making over the phone, or whether, instead, an in-person evaluation is required.

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7 Boxer, Brooks, and Gingrich; 2008
8 Boxer, Brooks and Gingrich; 2008
Timely attention to medical needs enables people to get well faster. If a person is traveling away from home for business or recreation and encounters difficulties in locating a physician to manage an illness or to refill a prescription, rapid telephonic consultation is extremely beneficial. In numerous situations, telephone-based cross-coverage enhances healthcare: employees who cannot leave the worksite; caregivers who cannot leave their charge to get healthcare for themselves; rural residents without access to a local physician.

Whenever people encounter impediments to accessing care—for any of these reasons or because their primary care physicians are not available during weekends, evenings and holidays—the physician telephone consult can close the gap.

Recognizing that healthcare costs must be contained, many proponents of telephone-based cross-coverage have developed fully transparent models that offer a flat rate fee schedule. This model mitigates the high costs of visits to the ER, urgent care center or physician office.

### Exhibit 1: Cost Comparison

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Average Cost</th>
<th>Total cost of visit (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER</td>
<td>$1029</td>
<td>$361-1262</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$194</td>
<td>$104-235</td>
</tr>
<tr>
<td>Physician Office*</td>
<td>$153</td>
<td></td>
</tr>
</tbody>
</table>

Sources: NC BlueCross BlueShield 2007; *2007 Provider Economics/Wellmark

Determination of cost savings is possible by identifying where the patient would have gone if the telephonic consultation was not available.
Exhibit 2: Demonstration of potential cost reduction based upon a survey sponsored by a telephone-based cross-coverage company.

Telephone-based cross-coverage supports these national trends:\textsuperscript{11}

- Equivalent healthcare outcomes at lower costs for participating Americans.
- Increased focus on high quality, affordable, private consultations that are easy to access.
- Streamlined, coordinated care through the use of an open, privacy-protected and encrypted Electronic Health Record (EHR).
- Widespread adoption of the medical home model and reliance upon primary care physicians.
- Timely care for rural Americans and the nearly one-in-four citizens who have problems missing work to see a doctor for routine medical services.
- Consumer-centric programs empowering individuals to purchase their own healthcare.
- Relieving pressures on overcrowded, understaffed hospital emergency rooms.
- Expanded practice options for physicians.

\textsuperscript{11} Arthur, Boxer, Thompson; 2008
Legal Issues Affecting Telephone-Based Cross-Coverage

Doctors have been practicing some form of telephone-based cross-coverage since the invention of the telephone. While communication technologies have evolved dramatically, laws governing this platform have not kept up with the pace of adoption. The problem remains that there is no universal law of telehealth medicine, and different states take significantly different approaches to regulating it.12

This patchwork quilt regulatory environment is likely to compromise the potential for telehealth in general and telephone-based cross-coverage in particular to act as a building block for healthcare delivery. Prominent leaders in both public and private sectors, including the American Bar Association, advise that the promise of this model will not be realized if the legal constraints surrounding it, particularly licensure restrictions, are not removed.13

State Licensure

With telehealth, as in conventional care, state licensure of physicians and healthcare practitioners remains obligatory. Individual states retain the authority to license physicians just as they retain the authority to pass medical practice act legislation governing what constitutes the "practice of medicine." This regulatory power has always been retained by the states and has never been delegated to the federal government. Though there are similarities in states’ definitions of medical practice, differences still remain.

Likewise, individual states retain the power to discipline their licensed physicians. As a result, no comprehensive national licensing standard or disciplinary formula exists. Though most states have licensure exceptions for those in the military who are transferred from location to location, no similar exceptions are universally available for civilian doctors. Many states provide licensure exceptions for emergencies or for care undertaken without the expectation of remuneration, but not for general practice across state lines.

States also license nurses, and for substantially the same reasons they license physicians. It is important to recognize that Registered Nurses (RNs) have embarked upon permitting some degree of cross-state licensure via the Nurse Licensure Compact.14 Essentially, this is a mutual licensure recognition agreement that addresses individual state licensing powers, scope of practice regulations and disciplinary matters. To date, there is no comparable licensure provision for physicians.


On August 11–12, 2008, however, the American Bar Association’s (ABA) House of Delegates adopted the recommendations of the ABA Health Law Section regarding proposed mutual telemedicine licensure recognition by all states.15 Telephone-based cross-coverage would fall into this broad category.

The Section’s Report outlines the numerous legal obstacles affecting these areas and discusses some of the recent efforts to lower these barriers. It also emphasizes the important benefits of this model, especially for individuals in rural areas who do not have the means to travel to distant providers, and how legal roadblocks are stymieing those benefits. According to the ABA, “…the most formidable barrier to the broad expansion of telemedicine (authors’ note: and presumably, telephone-based cross-coverage) services in the United States is the current need for multiple state licenses for physicians for practice across state lines.”16 The Report also highlights that “the needless complexity of requiring multiple state licenses flies in the face of those efforts to reduce costs” of providing healthcare to the citizens of the United States.17

Indeed, most states may be going in the wrong direction on this issue by developing individualized requirements on the practice of telehealth in each state. Individualized and inconsistent state regulations only make it more difficult for providers to practice telehealth in multiple states. Further, “physicians who practice telemedicine ‘without a license’ risk criminal as well as civil penalties, state disciplinary proceedings, and denial of coverage under medical malpractice insurance policies which generally require licensure as a condition of coverage.”18 Therefore, the risks associated with telehealth are a substantial deterrent to doctors considering whether to engage in the practice.

The disparity in the states’ approaches to telehealth is confounding in light of the states’ nearly uniform requirements for medical licensure for physicians wanting to practice in each state. Indeed, all states rely on generally the same national standards to license their physicians, such as graduation from an accredited medical school and a passing score on the standardized United States Medical Licensing Examination.19 Consequently, in the ABA’s view, “the substantial and ongoing administrative, financial and legal burdens that are imposed by requirements for multiple licenses for telemedicine practice outweigh any potential arguments in their favor.”20

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15 Demetriou, Andrew J.
16 Demetriou, Andrew J.
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18 Demetriou, Andrew J.
19 Demetriou, Andrew J.
20 Demetriou, Andrew J.
The ABA's proposed solution to this licensure problem is:

“…to institute a system of mutual licensure recognition whereby a physician with a current, valid and unencumbered license in any state could file a single application which would permit the physician to practice telemedicine in some or all other states subject to continuing compliance with those states’ licensure fees, discipline, and other applicable laws and regulations, and adherence to professional standards of medical care.21

In short, the ABA is proposing that licensed physicians be allowed to complete a single application that would allow them to practice telemedicine in some or all other states. Under the ABA’s proposal, state medical boards would retain their authority over physician licensing in their home states. However, the ABA’s proposal does not answer the question of how the mutual licensure recognition would be implemented, that is, whether by a proposed model code adopted by all states, by federal legislation applicable to all states or by some other method. While the ABA’s proposal appears sound, implementation of the proposal may prove to be a daunting and difficult task.

Medical Malpractice in Telehealth

Medical malpractice is but a species of negligence,22 the cause of action for an individual claiming to have been injured by another’s failure to exercise due care. Malpractice claims seek compensation for a patient allegedly harmed by a healthcare provider’s breach of the standard of care. State law defines the standard of care, but it generally means: that degree of skill and diligence which a reasonably prudent practitioner in the relevant specialty would have exercised under the same or similar circumstances at the time the case arose.

Malpractice litigation requires a comparison between the defendant physician’s care and that which a “reasonably prudent” peer physician would have provided under similar circumstances. When the two are comparable, there is no liability, regardless of outcome. If the defendant’s care is substandard, and the plaintiff can show he/she was harmed as a result, liability will rest with the defendant. Under current law, care provided at a distance will probably be compared with care provided face-to-face.

21 Demetriou, Andrew J.
As a general rule, claims for patient injuries can be based on a number of legal theories, including but not limited to:

**Lack of informed consent**... Did the clinician do something that the patient did not consent to?  
In several states, lack of informed consent is analyzed as a species of medical malpractice and not as a separate claim. State law may vary on this issue.

**Battery**... Did the clinician do a procedure or invade an area that the patient did not give consent for? Was there an unconsented touching?

**Malpractice**... Did the clinician perform in a manner less prudent than required by the applicable standard of care?

**Breach of contract**... Did the clinician indicate he/she was going to do one thing/procedure but do another instead, or fall short on some advertised representation?

**Breach of warranty**... Did the clinician promise or indicate a specific result/outcome would be achieved but it was not?

Of course, some of these claims may overlap. The key threshold when analyzing medical malpractice claims is whether, in a given situation, the practitioner failed to adhere to what is considered the “standard of care.”

In telephone consultations, plaintiffs might allege that the “standard of care” is more exacting than it is in conventional care. Depending upon the situation, issues involving technical and communication difficulties might arise. If medical data are being exchanged via electronic submission, it is important that there be safeguards in place so that they arrive at the proper destination. Additionally, the receiver should be fully capable of opening and viewing the data in their correct form. In cases of interactive telephone consultations, the reliability of the transmission and “delay” in time sequencing between the moment the instructions are sent and the moment they are received must also be addressed.

With the technology now available to secure expert consultations electronically, a patient who could have benefitted from a telehealth consultation but was denied it may assert that the defendant is liable for the omission. This theory has arisen in the travel industry at resorts, on airlines and aboard cruise ships to name a few.

**Jurisdiction**

In a malpractice claim against a telehealth practitioner, a basic question is what court has jurisdiction. Jurisdiction refers to the court’s legal authority to resolve the dispute. Historically, of course, patient and doctor usually lived and worked in the same community, and almost always in the same state. In many cases, they still do.

As a rule, any court of general jurisdiction within that state could hear any malpractice claim that a patient might bring against his or her doctor. In telehealth, the question is more complex because patient and physician need not necessarily be in the same jurisdiction, or even in the same country.
For example, a doctor practicing in North Dakota might have grounds to challenge a California court’s jurisdiction. If North Dakota’s laws are more favorable to the defense, he or she might well want to do so – especially to avoid the expense in time and money of mounting a defense half a continent away.

At the very threshold of the courthouse, then, the question is: which state’s law controls? For several reasons, the answer is critical. Unfortunately, that answer may not always be clear, and it may vary state-to-state. Often, the state where the patient lives will take the position that its law governs.

Juries and judges also vary considerably from jurisdiction to jurisdiction. So-called “judicial hell holes” are notorious for hostility to defendants. Other jurisdictions are much friendlier. The case’s outcome may well turn upon which jurisdiction ends up hearing the claim; identical facts in different jurisdictions can generate different results.

The Standard of Care

Another issue is the yardstick by which the defendant’s conduct is to be measured and what standard of care is at issue. Depending upon the state, the comparison the law requires between the defendant’s conduct and that of other practitioners may involve analyzing the work of physicians in the entire nation, in the defendant doctor’s state only, or, in a few cases, in a community similar to the one where the defendant practices.

A physician in a state maintaining a so-called state standard might be able to exclude testimony of another physician, however learned, who does not practice there—but only if that state’s law controls. If it doesn’t, the defendant’s care might be tested against a national standard. In practical terms, this distinction matters: the pool of experts, legitimate and otherwise, may be smaller than when the expert need simply be familiar with the national standard.

The law recognizes that jurors are rarely trained in medicine. Presumably, they are equipped neither to determine the standard of care nor to analyze causation, the element of the tort that inquires whether the alleged breach of the standard actually caused the harm complained of. A tort is defined as a civil wrong or breach of a duty to another person, as outlined by law.

In every state, the law provides for testimony by experts: individuals who by virtue of their knowledge, skill, training and experience are deemed able to assist the jury in making these determinations. The law also recognizes that the time of professionals such as these is valuable, and permits them to charge for it when consulting with litigants or their counsel. Many experts are just that, and testify sincerely. Some, however, are in the testifying business and considerably less honorable.

While tort reform is underway in many jurisdictions, the extent and effectiveness of tort reform varies substantially from state to state. Some have little or none while others have enacted comparatively effective tort reform, including such things as caps on damages, and various forms of mediation or arbitration. Whether tools such as these are available to the defense depends, once again, upon which state’s law controls. That determination could control the outcome. Moreover, insurance premiums are often a function, in part, of the effectiveness of the relevant state’s tort reform. Uncertainty about the extent to which a defendant doctor will benefit from tort reform may result in uncertainty about the premium to charge or limitations on coverage.
**Patient Privacy**

HIPAA emerges as a significant issue as it relates to medical records since any type of telehealth consultation will naturally involve some type of individually identifiable health information, as defined. Ideally, there should be an agreement up front as to what records will be stored/updated by each clinician; what type of security the storage of records will be subject to; and what part of an office, clinic, hospital or insurance entity the records may be a part of. Additionally, all parties in a telehealth consultation need to be vigilant about mistaken transmissions, hacking, improper disclosures and other privacy breaches. In this arena, there can also be concerns regarding what constitutes a “business record” and what is a “medical record” or personally identifiable medical information subject to greater protections.

Although HIPAA is undoubtedly the single most important statute pertinent to the privacy and security of medical records, it is not the only one. In particular, most if not all states also have statutes, regulations, common law, or some combination imposing duties upon providers and creating patient rights. In striving to comply with the requirements of HIPAA, healthcare professionals must not lose sight of the importance of complying with applicable state law as well.

**Reimbursement for Telehealth Consultations**

In many instances, reimbursement is seen as the “engine” that drives telehealth consultation practice. While the technology may be readily available, easy to use, and effective, the lack of reimbursement may present a significant barrier.

Various payment sources tend to handle this issue differently, with Medicare, Medicaid and private insurers having differing policies. Practitioners will be unlikely to whole-heartedly adopt the use of new technology unless adequate reimbursement is available. If and when there is widespread and adequate reimbursement for various types of telehealth consultations, there will likely be a significant uptick in utilization.

The recent passage of Medicare Bill H.R. 6331 will change reimbursement for telehealth services. The Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331) became public law on July 15, 2008 when Congress overrode a Presidential veto. The Act included a relatively modest, but important, expansion of Medicare’s reimbursement for telehealth services, which shall apply to telehealth services provided after January 1, 2009.

Specifically, the Act added three (3) additional “originating sites” for Medicare reimbursement:

1. Hospital-based or critical access hospital-based renal dialysis centers (including satellites);
2. Skilled nursing facilities; and
3. Community mental health centers.
Before passage of the Act, the only originating sites were physician offices, critical access hospitals, rural health clinics and federally qualified health centers. An “originating site” is the location where the patient receiving the telehealth services is located, and a “distant site” is the location where the physician providing the telehealth services is located.23 While the addition of the telehealth originating sites is welcome news to some providers, the new originating sites must also fulfill the other narrow Medicare requirements in order for providers to receive reimbursement.

Most importantly, to qualify as a telehealth originating site, the site must be one of the seven types of facilities listed in the statute and must also be located (i) in a rural health professional shortage area, (ii) in a county that is not included in a Metropolitan Statistical Area or (iii) from an entity that is participating in a Federal telemedicine demonstration project.24 Therefore, only rural healthcare facilities and a few other types of facilities will be able to provide Medicare-reimbursable telehealth services to patients. Additionally, the sites must ensure that the individuals receiving the services qualify under Medicare and that the site complies with all other Medicare requirements.

Ultimately, this change in the Medicare laws may be modest, but many in telehealth, including the American Telemedicine Association, view it as a significant victory.25 It is another step on the long road to broader reimbursement of a full range of telehealth services.


24 Medicare Telehealth Enhancement Act of 2005

Telephone-Based Cross-Coverage

Clinicians participating in telephone-based cross-coverage deliver cross-coverage consultations 24 hours a day, 7 days a week, and 365 days a year, response times vary; in at least one case, they are generally under 30 minutes.

Advantages of telephone-based cross-coverage:

- Rapid access to a primary care physician (via telephone).
- Telephonic cross-coverage that handles acute, episodic, self-limited, minor, and chronic illnesses.
- A fully portable Electronic Health Record (EHR), available 24/7, delivered on demand worldwide.
- Longer consults. Studies have demonstrated that telephone consultations furnished via telephone-based cross-coverage are typically 10 minutes vs. national average for office visits running 3-6 minutes.
- Welcome for patients with pre-existing conditions.
- Concierge-type medicine.
- Cost-efficiency: Because costs are well understood, telephone consultations come with a transparent and typically low price tag.
- Patient satisfaction.

Prescriptions

One of the key value points of telehealth consultations is the ability of physicians to prescribe medications. Controls should be in place to establish limits however: short-term prescriptions or refills of no more than one month and no DEA-controlled substances or lifestyle drugs (generally defined as drugs taken to satisfy a non-medical or non-health-related goal). The EHR should reflect each script with an alert message (flagged) that the patient has received a refill from a telemedicine consult to prevent abuse of this benefit.

Quality of care

Robust oversight of all consults and a formal Continuous Quality Assurance (CQA) program conducted by physicians should be an integral part of any telehealth program, with a baseline requirement stipulating automatic review of some fraction of all consultations. These CQA activities should include benchmarking of quality standards, establishing guidelines for treatment, and articulating current best practices and standards of care. All data collected should be available for self- and outside audits, creating a simple transparent system that incorporates quality indicators for each patient record.

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Flower, Rod. Lifestyle drugs: pharmacology and the social agenda; Department of Biochemical Pharmacology, The William Harvey Research Institute, Charterhouse Square, London EC1M 6BQ, UK; http://www.find-health-articles.com/rec_pub_15063081-lifestyle-drugs-pharmacology-social-agenda.htm; Accessed 2/19/09.
It will be important to monitor patient utilization of services to identify individuals who may be over-utilizing the system. These cases should be queued for physician review, pointing to a need for supplementary evaluations and triggering additional research as warranted to further clarify each patient’s health needs. When utilization is more frequent than would be anticipated, it will be critical to determine if the patient has a recurring or chronic illness that may need more than episodic care. Any patient who has used a telemedicine consult service for a chronic, recurrent issue and/or for an emergent need and/or who has used the service more than twice per month, for example, should be admonished to seek face-to-face care from a doctor.

Once physicians are performing telephone consults, they should be reviewed on a regular basis to determine whether they meet standards of care. The following tools should be in place to promote optimal performance:

• Daily random audits to identify general medical appropriateness. Any variances outside certain pre-defined parameters are flags for further investigation and action as warranted

• Key issue audits conducted monthly to focus on specific issues of particular importance in this environment or employer-specific audits as requested

• Satisfaction survey results reporting patient satisfaction after their consults. Any issues arising from this process should be specifically investigated and appropriate actions taken

• Outcomes review of specific cases, chief complaints, and other benchmarks should also be reviewed regularly. These would be actual case-specific issues that arise and are deemed to warrant review outside the normal process described above

• Outcome studies will help to determine effectiveness of the encounter. Data should be compared on a per physician basis to assure continued quality encounters

To promote accountability, a mechanism should be created to solicit patient feedback and evaluate levels of satisfaction with the consultation.

Finally, rules should be established for all prescriptions written by telephone-based cross-coverage physicians with ongoing monitoring of all prescriptions to see that physicians prescribe only those medications that are appropriate for the patient encounters. As a caveat, policies should be in place to prohibit physicians from authorizing multi-month refills or prescribing controlled medications—including “pleasure drugs” (e.g., erectile dysfunction medications). Furthermore, physicians should be trained and held accountable for the correctness of the prescriptions, appropriately considering such issues as allergies, contra-indications, and potential drug interactions.

27 Boxer, Brooks and Gingrich; 2008
The ideal telephone-based cross-coverage service gives the patient, physician and the payer the following advantages: 28

- Easy accessibility for the patient
- Quality care with quality oversight
- Clinicians who return consultation requests promptly
- Affordability for the patient and the payer
- Efficiency for the patient and the physician regardless of their locations
- Convenience for the patient
- High patient satisfaction
- High productivity from a healthy workforce that need not leave work for a doctor’s appointment or ER visit
- Reliable searchable interaction data
- Privacy-protected, portable and instantly accessible medical records to improve the quality of care
- 24/7/365 coverage throughout the U.S.
- Rapid access for rural and urban populations
- Reasonable and rapid pay for physicians incentivized to work and covered for malpractice
- Allied in principles and practices of the American primary care professional

28 Arthur, Boxer, and Thompson; 2008