

**Telemedicine in Michigan:**  
**A Policy Report Addressing Legal and Regulatory Barriers**

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In Cooperation with the State Telehealth Working group

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## Telemedicine in Michigan: A Policy Report To Address Legal and Regulatory Barriers

### **I. Introduction**

The Office for the Advancement of Telehealth (OAT) defines “telehealth” as: “...the use of electronic information and telecommunications technologies to support long-distance clinical care, patient and professional health-related education, public health and health administration.” Emergence of the Internet and diffusion of high-bandwidth telecommunications technologies are just beginning to enable telehealth applications to address the burgeoning needs of our society for greater access to healthcare services at a lower cost.

Michigan, however, is falling behind other states in its efforts to promote the advancement of telehealth applications. For instance, while Michigan has not yet addressed issues pertaining to licensure of providers who practice telemedicine across state lines, Alabama and other states have passed legislation recognizing (for telemedicine only) the license a practitioner holds in another jurisdiction. Whereas Michigan lacks the infrastructure to make available broadband access beyond a T-1 line in most parts of the state, Arizona has been able to attain OC-12 bandwidth (About 400x greater than T-1) within 10 miles of 90% of its population. Medicaid providers in Michigan are not eligible for reimbursement for telemedicine consultations, even though 26 other states provide this coverage.

In order to maximize the effective use of technology to deliver health services in Michigan, it is vital that key health providers, regulators, and policy experts work together to assess and make recommendations to enhance the situation.

### **A. Rationale for this Project**

Several factors point to the need for developing policies to enhance the advancement of telemedicine in Michigan. The cost of healthcare continues to outpace inflation generally. As medical science advances, additional procedures and treatment protocols are continuously added to the list of necessary services. The aging of the “Baby Boom” generation means that an increasingly larger percentage of our population will need care for chronic illnesses and conditions, and also that a smaller percentage of our population will be called upon to pay for that care. In addition, the population of our state is widely dispersed geographically, whereas healthcare providers, especially specialists and sub-specialists, tend to be concentrated in the larger urban centers. Moreover, Michigan’s position as a leader in healthcare science enhances the state’s ability to attract healthcare providers and students of the highest caliber, thereby ensuring the residents of Michigan with continued access to world-class healthcare services.

This project was designed to identify and address policy issues that potentially could impede the diffusion of telemedicine in Michigan. Following initial research as to the nature and extent of barriers to the diffusion of telemedicine, and solutions that have been attempted elsewhere, a team of key health leaders and telemedicine providers was convened. (See Table 1). The Working Group on Telemedicine Policy for Michigan developed several of the specific recommendations offered herein and has had extensive input to prior versions of this report. The author wishes to express sincere gratitude to all the members of the Working Group for their generous and insightful contributions to this project.

## II. An Overview of Telemedicine

The use of telecommunication technologies for medical diagnosis, care and education has traditionally involved use of interactive video for synchronous delivery of care. Interactive video (ITV) services are fully synchronous. In this type of application, two or more parties are both physically present in front of ITV equipment, and can see and hear each other. Of course, the quality of the interactions depends upon the equipment and transmission speeds used.

Telemedicine techniques, as defined previously, have developed over the past four decades. Wittson, Affleck and Johnson (1961) were the first to employ telemedicine for medical purposes in 1959 when they set up telepsychiatry consultations via microwave technology between the Nebraska Psychiatric Institute in Omaha and the state mental hospital 112 miles away (See also, Jones and Colenda, 1997). In the same year, Montreal, Quebec, was the site for Jutra's (1959) pioneering teleradiology work.

In the 1970's, there was a flurry of telemedicine activity as several major projects developed in North America and Australia, including the Space Technology Applied to Rural Papago Advanced Health Care (STARPAHC) project of the National Aeronautics and Space Administration (NASA) in southern Arizona, a project at Logan Airport in Boston, Massachusetts, and programs in northern Canada (Dunn, Conrath, Acton, Higgins, Math and Bain, 1980).

Although data are limited, early reviews and evaluations of these programs suggest the equipment was reasonably effective at transmitting the information needed for most clinical uses and users were mostly satisfied (Conrath, Puckingham, Dunn and Swanson, 1975; Dongier, Tempier, Lalinec-Michaud and Meunier, 1986; Fuchs, 1974;

Murphy and Bird, 1974). Interestingly, with the exception of one simple program at Memorial University Hospital of Newfoundland, no telemedicine programs survived past 1986. When external sources of funding were withdrawn, the programs simply folded.

The decades of the 1960's, 1970's, and 1980's exhibited a series of telemedicine pilot and demonstration projects. However, the 1990's have proven to be a period of rapid growth. In the early 1990's, new, fairly inexpensive, and commonly available digital technologies enabled video, audio and other imaging information to be digitized and compressed. This facilitated the transmission of information over telephone lines with relatively narrow bandwidths, instead of through more expensive satellites or relatively unavailable private cable or fiber optic lines. In 1990, there were four active telemedicine programs. By 1997, there were almost 90 such programs and by 1998, there were 200 documented telemedicine programs (Whitten, in press).

Today, so many health systems employ some form of telecommunication technology to deliver health services or education that it is no longer possible to quantify the number of telemedicine programs. (Whitten, in press). The fact that the U.S. federal government will spend close to one billion dollars this year on telemedicine research, grants and other funding is strong evidence of telemedicine's growing proliferation. Major funding areas include R&D, infrastructure development, information management, and health care delivery. (Federal Telemedicine Update, 2001).

Studies indicating telemedicine is a viable alternative for health-care treatment are noteworthy (Dunn, Choi, Almagro, Recla and Davis, 2001; Korhonen, et al. 2001; Perednia and Allen, 1995; Whitten, Cook and Doolittle, 1998; Whitten, et al., 2000). Indeed, research findings related to medical efficacy and satisfaction testify to the



feasibility of this alternative. As Allen, Cox and Thomas (1992) reported: "...the telemedicine interaction was found to be a reasonable substitute for an on-site patient-physician encounter, in terms of patient-physician satisfaction and ability to transmit information and diagnosed." (p. 323).

Visions into the future of telemedicine already point toward the application of a combination in changes in the telecommunication marketplace and changes in the health care industry. Advances in such innovations as wireless technologies, biosensors, smart cards, and virtual reality all point to a need to be proactive in maximizing the effectiveness of telemedicine today so that we can smoothly transition into the use of these cutting edge solutions. Telesurgery is no longer a distant dream. For example, Guillonneau and colleagues (2001) demonstrated the feasibility and safety of remote laparoscopic surgery using a surgical telemanipulator. A robot assisted, transperitoneal right laparoscopic nephrectomy was performed on a 77-year-old woman was diagnosed with a nonfunctioning hydronephrotic right kidney. A complete dissection was successfully performed with the robot. We are poised at the crossroads of phenomenal technological advancements. It is imperative that we make sure we create an environment in Michigan that safely and effectively facilitates health delivery via these innovations.

### **III. Barriers to the Diffusion of Telemedicine**

Given that telemedicine offers the potential for improved access to quality healthcare at a lower cost, the inherent relative advantage of telemedicine should in and of itself be the primary driver of its diffusion throughout Michigan. However, our research indicates that several policy considerations may be impeding the diffusion of telemedicine.

Our research included an extensive review and content analysis of hundreds of journal articles, more than 25 Web sites and several books addressing policy implications for telemedicine. We found that the policy barriers to the diffusion of telemedicine applications may be classified into five broad categories: a) licensure, credentials and certification; b) payment and reimbursement; c) safety, standards of care and liability; d) infrastructure; and e) privacy, security, and confidentiality. This section focuses upon identifying and defining those policy-related barriers, and discusses relevant recommendations and steps made elsewhere.

### **A. Licensure, Credentials, and Certification**

The practice of medicine, nursing, and most all healthcare professions and para-professions is regulated on the state level. The privilege to practice in a hospital, for instance, is generally conferred by each facility individually.

But telemedicine may present new challenges to these paradigms. By definition, telemedicine makes it possible for a caregiver in one place to consult, diagnose or treat patients in another place. This raises issues about the legal authority of a caregiver to provide telecare to patients across state lines, or in hospitals the provider may have never physically visited.

An understanding of these issues requires as a threshold some conceptual definitions of the relevant terms. OAT offers the following definitions:

- Licensure: The legal authority to practice
- Certification: A procedural requirement typically requiring some specialized training and culminating in the award of a document acknowledging the holder's competency to ensure that health care professionals meet defined standards for the specified practice. Examples of commonly measured certification levels include:
  - Tasks – e.g., Intravenous therapy
  - Bodies of Knowledge (specialty): e.g., Informatics
  - Expert Practice: Medical Specialty Board
- Credentialing: Documentation that supports professional education, training and experiences.
- Privileging: The right to practice in a specific work environment with identified constraints. Examples include:

- Admitting Privileges
- Clinical Privileges
- Accreditation: Acknowledgement granted to an organization that certain standards are being met

The following subsections identify specific recommendations and steps taken elsewhere for particular aspects of these issues.

### **1. Physician Licensure**

Several organizations have studied the issues presented by the licensure implications of physicians practicing telemedicine across state lines. The Federation of State Medical Boards of the United States, Inc. has adopted a model act to regulate the practice of telemedicine across state lines. Its proposal establishes a special limited license that would not allow the holder to practice medicine while physically within the jurisdiction. Only those who “regularly or frequently” practice interstate medicine would be required to obtain it. Physician-to-physician consultations and emergency consultations would be exempt.

The American Medical Association, in contrast, advocates that states and their medical boards should require a full and unrestricted license for all physicians practicing telemedicine within a state (i.e., rendering care to a patient physically located within the state, regardless of the location of the physician). The American College of Radiology recommends that practitioners be licensed both where images are transmitted and received. The College of American Pathologists has supported an endorsement system, under which physician licenses are endorsed in each state from which they receive specimens or patient information.

The Health Care Law Committee of the Young Lawyers Section of the American Bar Association recommended that Congress enact legislation enabling a physician licensed in any state to engage in telemedicine in any other state without limitation, so long as the ultimate decision making authority for the patient's care remain with a local physician.

The American Telemedicine Association proposes an entirely different paradigm. Under the ATA proposal, the patient in a telemedicine encounter is considered to have been transported to the state where the patient's information is received. The physician at the receiving location would not need additional licensure outside the state in which the physician is located if certain "rules of engagement" are met: a) the request originates from a physician licensed in the patient's state; b) the patient and requesting physician have a face-to-face encounter; c) the out-of-state consultant is licensed in the state in which he is located, and; d) the requesting physician retains the ultimate decision making authority over care decisions.

In practice, many states have generally adopted one of three paradigms for licensure of physicians who practice telemedicine across state lines: a) requiring full licensure; b) creation of a limited license or endorsement, or; c) establishment of exemptions, exclusions and exceptions allowing out-of-state physicians to practice telemedicine without additional licensure.

About 26 states (not including MI, see Table 2) have adopted laws requiring full licensure for physicians to practice telemedicine across state borders. In Florida, for instance, a physician not licensed in Florida engages in the unauthorized practice of medicine if he or she reviews medical tests of a Florida patient that have not first been

reviewed by a Florida-licensed physician. Only a Florida-licensed physician may order telemedicine services for patients in Florida. The Florida Board of Medicine reported that while telemedicine can lower costs and improve medical service, it also has the potential for: "...more sloppy medicine by emphasizing quantity over quality, cheaper over fair fees for services, and by creating excessive competition for referrals."

Other states (e.g., AZ) create exceptions to licensure requirements for episodic or infrequent teleconsultations. In some states, the teleconsultation exception is limited to requests from physicians licensed in the state. In some states this locally licensed physician must practice the same medical specialty as the telecare provider. Other states (AL, CO, MT & OR) recognize for telemedicine only a license that a practitioner holds in another jurisdiction.

Another alternate licensure paradigm is found in California. There, the Medical Board maintains a "registration system" under which out-of-state physicians who practice telemedicine there can register with the state. However, to date, California still retains the full licensure requirement.

Reciprocity is a paradigm also relevant to this issue. Under reciprocity, states, which include Michigan, recognize licenses from other states, allowing the applicant to become licensed in the locality without the necessity of repeating the National Medical Board Exam.

## **2. Nursing Licensure**

The National Council of State Boards of Nursing adopted the Interstate Nurse Licensure Compact. It creates uniform standards for nursing licenses and permits interstate practice by nurses in all states that adopt the compact. About 12 states (not

including MI, see Table 3) have adopted the compact to date. Unlike reciprocity systems, the nurse does not have to file paperwork or pay fees to a multiplicity of jurisdictions. Rather, licensure in any one of the states that has adopted the compact automatically bestows the right to the nurse to practice in all states that have adopted the compact. While the state issuing the license maintains primary authority over her privileges, the nurse is subject to disciplinary proceedings in any jurisdiction in which she practices.

### **3. Credentialing and Privileging**

For most practitioners, a licensure is of limited value unless the practitioner is also granted privileges at one or more hospitals. Most hospitals' credentialing processes are heavily influenced by the national requirements of the Joint Committee on the Accreditation of Healthcare Organizations.

Effective January 1, 2001, JCAHO requires that organizations must credential and privilege providers who: "...diagnose or treat patients via telemedicine link." Organizations may rely upon credentialing information from another Joint Commission accredited facility, but the decision to delineate privileges must be made at the facility receiving telemedicine services. Practitioners that may be called upon to provide telemedicine services on a one-time or very rare occasion would apparently fall under temporary privilege standards addresses by JCAHO standard MS5.14.4. There may be some gray area between rendering a "diagnosis" versus merely offering an "opinion".

### **4. Certification**

Although it has been suggested from time to time, to our knowledge there is no jurisdiction that requires a special certification procedure in order for a licensed healthcare professional or paraprofessional to obtain special certification to render

telecare. Rather, just as providers have been able for decades to use an ordinary telephone to supplement their provision of care without additional training, it has generally been presumed that providers who employ telehealth technologies will do so in accordance with the standards that govern their conduct generally, without the need for additional specialized training.



## **B. Payment and Reimbursement**

Reimbursement is obviously a necessary component for the broad diffusion of telecare. So far, reimbursement for telecare has been limited and somewhat haphazard. Private and public payers have been reluctant to reimburse telecare services on par with face-to-face services.

Historically, Medicare has paid for some telemedicine services that do not traditionally require face-to-face interaction with patients, such as teleradiology and telepathology. However, until recently, consultations and “office visits” had to be face-to-face to be eligible for reimbursement.

The Balanced Budget Act of 1997 (BBA) requires the Health Care Financing Administration (HCFA) to pay for some telemedicine consultation services to Medicare recipients effective January 1, 1999. However, several administrative limitations restricted the effectiveness of this legislation.

- Patients had to be located in Rural Health Professional Shortage Areas (HPSAs). This overlooked many patients who had access to general practitioners but not to specialists.
- Consulting physicians received only 75% of the normal fee for their services; the presenting physician received the other 25%. Moreover, HCFA reported payment to the IRS at 100%.
- The presenter couldn't be a nurse, even though nurses are the only healthcare staff at most rural clinics.
- Store-and-forward consultations were excluded.

- Home health services were excluded.
- Few CPT codes were eligible for reimbursement.

As of September 30, 2000, some 22 months into the program, Medicare had reimbursed only \$20,000 for 301 teleconsultation claims. (Medicare paid over \$4 Billion in claims for 1999-2000).

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (S.B. 2505) sought, among other things, to redress some of these limitations.

Medicare reimbursement guidelines are changed as follows effective October 1, 2001:

- Teleconsultation services to Medicare patients in all counties outside of MSAs, as well as federal demonstration projects, are eligible for reimbursement. (As before, it is the location of the origination site, not the patient's residence, that controls)
- The fee-sharing provisions are eliminated.
- The qualified presenter requirement is eliminated.
- The originating site becomes eligible to be reimbursed a \$20 facility fee.
- CPT codes eligible for reimbursement have been expanded. The eligible codes will now include:
  - Consultations (CPT codes 99241-99275)
  - Office or other outpatient visits (CPT codes 99201-99215)
  - Individual psychotherapy (CPT code 90804 - 90809)
  - Pharmacologic management (CPT code 90862)
- Store-and-forward consultations become eligible for reimbursement only for federal demonstration projects in Alaska and Hawaii.
- Home health services remain ineligible for Medicare payments.

Home health care services present a unique situation. Under Medicare, home health care agencies are specifically authorized to use telemedicine as a part of the services they render to Medicare patients. However, the telemedicine encounters are not considered a visit for purposes of payment or eligibility.

In contrast to Medicare, HCFA's Medicaid program leaves it to the states to decide if telemedicine services are eligible for reimbursement. About 20 states (not including MI, see Table 4) now provide Medicaid coverage for some telemedicine consultations. HCFA encourages states to create innovative payment methodologies. For instance, costs associated with telecommunications equipment and line charges may be incorporated into a fee-for-service rate or separately reimbursed as an administrative cost.

On the private-payer side of the reimbursement issue, Blue Cross/Blue Shield and a minority of other private health insurers pay for select telemedicine services in some states. BC/BS, for example, pays for telemedicine services in Kansas, Montana, and North Dakota. In California, BC/BS is also developing a telemedicine network of its own. California, Hawaii, Texas and Louisiana have passed legislation prohibiting private health insurers from discriminating between traditional medical and telemedicine service reimbursement. California Insurance Code Section 10123.85c provides in pertinent part:

*On and after January 1, 1997, no disability insurance contract that is issued, amended or renewed for hospital, medical, or surgical coverage shall require face-to-face contact between a healthcare provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the contract agreed upon between the policyholder or contract holder and the insuree.*

### **C. Safety, Standards of Care and Liability**

Will telemedicine raise or lower malpractice liability exposure? On the one hand, telemedicine consults involving two or more physicians may increase the quality of care. Access to electronic databases also may lead to better patient outcomes. However, as technology becomes more sophisticated, patient expectations may increase. Deficiencies or failures in equipment, or failure to upgrade telemedicine communication systems as technologies advance, may increase claim exposure.

Legal standards for medical malpractice in the U.S. appear to be the same for a traditional or telemedicine encounter. The threshold question is whether a provider-patient relationship exists. A provider-patient relationship can be implied by provision of medical care. Most teleconsultations would presumably be viewed as establishing the requisite provider -patient relationship.

Once the existence of the relationship is established, the issue then becomes whether the physician breached the appropriate standard of care. Providers must exercise that degree of care and skill ordinarily exercised by other members of their profession. Whether mediated contact through telecommunication technology will impact the standard of care, and if so how, has yet to be determined.

#### **1. Practice Guidelines**

Guidelines suggest or recommend specific professional behavior or conduct in the delivery of health care services. They ideally are intended to foster “best practices” to be used in particular circumstances or settings. Practice Guidelines are generally based upon expert consensus rather than empirical evidence. They often address areas of controversy or uncertainty and may be useful in a medico-legal context.

The American College of Radiology has developed practice guidelines for teleradiology. The AMA has encouraged other medical specialty societies to develop appropriate practice parameters, but these have not yet materialized. The American Telemedicine Association Special Interest Group for Telepathology has proposed draft guidelines for telepathology. The Board of Directors of the American Telemedicine Association has adopted a set of clinical guidelines for the use of telemedicine for homecare.

In the absence of formal guidelines, each practitioner and facility must ensure that the quality of diagnostic and therapeutic capabilities do not jeopardize the patient. Moreover, the decision to use telemedicine in a particular situation must itself comply with the appropriate standard of care. Conversely, the day may be approaching where failure to deploy a telemedical consult constitutes lack of due care.

## **2. Technical Standards**

Technical standards pertain to properties of hardware, software, data transmission equipment and the like. Equipment vendors and telemedicine systems are responsible for ensuring that technical capabilities can meet clinical needs, but practitioners are also responsible for being aware of these issues in order to ascertain whether satisfactory care can be rendered.

The American College of Radiology has developed technical standards for equipment used for remote imaging interpretation. ATA's Telehomecare Clinical Guidelines include standards for technical equipment.

More generally, the Food and Drug Administration attempts to ensure the safety and reliability of medical devices, including some telemedicine devices. However, telemedicine technologies are developing rapidly. The role the FDA and/or other federal or state agencies will play in this field remains to be specifically defined.

## **3. Liability Insurance**

Practitioners purchase malpractice insurance to protect themselves against claims and litigation expenses attendant thereto. Practitioners may be reluctant, and wisely so, to engage in practices excluded from coverage. Liability insurers determine malpractice premiums on the basis of actuarial considerations of the risks assumed by the policy contract. The practice of telemedicine might involve exposures not present in traditional medicine. Should malpractice carriers be permitted to exclude telemedicine from coverage or charge practitioners who engage in telemedicine an additional premium for a telemedicine rider?

It appears that insurers in at least some places are already beginning to consider this issue. For instance, Northwest Physicians Mutual Insurance Company's application for malpractice coverage already requires applicants to disclose whether engage in the practice of telemedicine (Appendix 1).

#### **D. Infrastructure**

Section 254 of the 1996 Telecommunications Act required the Federal Communications Commission (FCC) to explore ways to enhance rural health care providers' (HCPs) ability to obtain high-speed telecommunications services for provision of telemedicine. On May 8, 1997, the FCC released a report outlining a funding mechanism to achieve this goal. The idea was that rural health care providers would receive a subsidy equal to the difference between the actual cost of high-speed service in their area and the cost of a comparable high-speed connection in the nearest urban community. The FCC allocated \$400 million per year for 4 years from the Universal Service Fund for this purpose.

In reality, the Universal Service Fund (USF) has done little to foster diffusion of telemedicine to rural communities.

- Between January 1, 1998 and June 30, 1999, a mere \$3.4 million was paid to HCPs; an additional \$6.1 million was paid during the 1999-2000 fiscal year. (Out of an \$800 million allocation)
- Eligible services were limited to a bandwidth of 1.544 Mbps (the equivalent of a T-1 line).
- The application process is exceedingly complex and requires involvement of a local telephone company.
- Benchmarks to calculate subsidies reflected “list” rather than actual “discount” rates paid by many urban HCPs, artificially reducing the real difference in expenditures.



The T-1 limit and urban comparison were dropped effective July 1, 2000. Nevertheless, the FCC expects fiscal 2000-2001 funding to remain under \$10 million. The OAT concludes that: “ While some telemedicine practitioners can benefit from the FCC discounts, they are no substitute for the possible economic benefits that competition in the area could bring. Competition has not yet reached rural America where it is most needed.”

The history of the FCC’s attempts to provide broadband access to rural HCPs is not encouraging. Moreover, there is no guarantee the meager efforts to date will be extended beyond 2002. Therefore, if HCPs in Michigan are to receive reliable broadband access, this problem must be viewed in the larger context of Michigan’s telecommunications infrastructure in general.

The Michigan Economic Development Corporation (MEDC) recently issued the *LinkMichigan* plan, a set of policy recommendations to facilitate development of advanced telecommunications infrastructure here in Michigan. MEDC reported several problems at present:

- Limited availability for bandwidth higher than a T-1 line
- Great price disparities for T-1 service
- Lack of information as to what telecommunications infrastructure is in place
- Lack of coordination between competitors who are installing infrastructure

By comparison, Arizona, for example, has infrastructure with OC-12 bandwidth (About 400x greater than T-1) within 10 miles of 90% of its population.

The *LinkMichigan* plan made four major recommendations:

1. Statewide Public User Aggregation

- Aggregate collective purchasing demand of the state, municipalities, schools, and other public partners.
- Require the winning bidder to maintain a high-speed backbone infrastructure that extends to most regions of the state.
- Require the winning bidder to resell excess capacity to competitors at non-discriminatory prices.

2. Tax and Permitting Fairness

- Establish one equitable tax and fee system for all telecommunications and information carriers
- Establish a unified right-of-way permitting system

3. Access to Information

- Require all telecommunications and information carriers to provide specific network location and capability information
- Develop and enforce quality-of-service standards
- Link reporting to right-of-way permits

4. Community Assistance

- Provide planning grants to municipalities to develop their own last mile solutions
- Encourage communities to link their strategies to the statewide backbone initiative

## **E. Privacy, Security, and Confidentiality**

OAT offers the following “non-official ‘working definitions’” of these concepts:

- **Privacy:** An individual’s claim to control the use and disclosure of personal information.
- **Confidentiality:** A status accorded to information that indicates it is sensitive for stated reasons and therefore must be protected and access to it controlled.
- **Security:** The safeguards (administrative, technical, or physical) in an information system that protect the system and its contents against unauthorized disclosure, and limit access to authorized users in accordance with an established policy.

### **1. HIPAA**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Department of Health and Human Services (HHS) to develop regulations relating to privacy standards. Those regulations went into effect April 14, 2001 – most entities have until April 14, 2003 to comply. The rules apply to “covered entities”, a rather broad term that applies to health plans, health information clearinghouses, and healthcare providers engaged in electronic transactions, including private and public entities. Some of the highlights of these regulations are as follows:

- Applicable to health plans, health care clearinghouses, and those healthcare providers who conduct certain financial and administrative transactions (e.g. billing) electronically.
- All medical records and personally identifiable information is protected, be it electronic, on paper, or oral.

- Providers and health plans are required to give patients a clear written explanation of how their health information may be disclosed.
- Patients have right to view, copy, and ask for amendments to their records.
- Patients must be told of non-routine disclosures of their records.
- Patients must give prior written consent to disclosure of their records; a separate written consent is required for each non-routine disclosure and most non-health care purposes.
- Records may not be disclosed for most non health-care purposes, such as to employers or insurers without specific patient authorization.
- Disclosures must be limited to the minimum amount of information necessary (but this does not apply to disclosure for treatment purposes).
- Covered entities must adopt written privacy procedures. These must include who has access to protected information, how it will be used within the entity, and when it may be disclosed.
- Employees must be trained in privacy compliance procedures.
- A privacy officer must be designated.
- Trading partner agreements are necessary to assure that outside entities protect patient information shared with them.
- Civil penalties are \$100 per violation, up to \$25,000 per person per year.
- Criminal penalties for knowingly violating these regulations are up to \$50,000 and 1 year in prison for obtaining or disclosing protected information, up to \$100,000 and 5 years in prison for doing so under “false pretenses,” and up to

\$250,000 and 10 years in prison for doing so with intent to sell, transfer or use it for commercial advantage, personal gain or malicious harm.

- HHS projects the costs of compliance at \$17.6 Billion over 10 years.
- Stronger state laws continue to apply.

The Health Privacy Project at Georgetown has compiled a 50-state survey of state health privacy statutes available at: [http://www.healthprivacy.org/info-url\\_nocat2304/info-url\\_nocat.htm](http://www.healthprivacy.org/info-url_nocat2304/info-url_nocat.htm), however, as of December, 2001, the site claimed to be current only as of August 1999.

#### **IV. Telemedicine in Michigan**

Numerous telemedicine projects are already delivering services to patients and providers throughout Michigan. Described below in no particular order are a handful of these projects to exemplify the types of telemedicine applications that successfully render services to Michiganders at present.

The **Marquette General Health System/ Upper Peninsula Telehealth Network** is among the oldest active telemedicine projects in Michigan. What started in 1994 as a small effort to provide distance learning to physicians among five initial sites has led to a sophisticated 25-site network providing 2000 connections annually. UPTN provides core services in professional/staff education, the medium for clinical consultations, the medium for administrative meetings, deployment of telehome care systems, community education and video conferencing services for community groups/businesses. Marquette General Health System (MGHS) is the hub for the 30-site network and provides the support functions among the independent sites. The support functions include administration of the multipoint control unit, communication and coordination among network members, advocacy for advancements on telehealth policy, technical assistance, educational programming, grant administration and promotion of applications.

Before the initiation of the **Beaver Island Telehealth Project**, only primary health care and minor emergency services were provided at the Beaver Island Rural Health Center (BIRHC) under the direction of a Family Nurse Practitioner. A doctor visits the island bi-monthly to see patients and review records. There are no psychiatric counseling, crisis intervention, or Medicare-certified home care services. Volunteers provide hospice care. The Beaver Island telehealth project was implemented in order to

link local health care staff to doctors, nurses, hospital staff and educators in Northwest Michigan hospitals. Clinic-based telehealth equipment has been installed in the clinic. Additionally, this grant has provided tele-home health units which allows patients to receive some health care in their homes. Prior to this grant, no home health care services were available for island residents.

**LifeWays, in Partnership with Michigan State University**, is creating a unique telehealth network which will address the full continuum of care for the bi-county rural region in Michigan. Services are provided to adults and children with mental illness and developmental disabilities. Services cover the entire spectrum of psychiatric care following a biopsychosocial model for Medicaid and non-Medicaid populations. This comprehensive project has included a wide range of services, including a link between rural mental health clinics, to a county jail, to a crisis stabilization center, and directly into patients' homes.

The **University of Michigan Telemedicine Resource Center** serves to integrate telemedicine into the mainstream activities of patient care, research, and education at the University of Michigan Health System (UMHS). The TRC assists in the development and provision of medical expertise for a network of providers across the State of Michigan and beyond. These efforts are in accordance with the UMHS mission to improve the health and well being of the people of Michigan and all its clinics. Through the use of telemedicine information technology, the TRC serves as a resource and conduit for the application of UMHS clinical, diagnostic, and educational expertise at the national and international levels.

The **Michigan Dept. of Corrections** has telemedicine links to 13 sites with 20 participating physicians providing care in 14 subspecialty areas.

**Hospice of Michigan, in Partnership with Michigan State University**, is one of the nation's first telehospice projects. Recognizing the need to explore innovative solutions to enhance end-of-life care, this service uses telemedicine technologies to deliver hospice care to patients' homes in rural and urban Michigan locations.

**REMEC Telehealth Network**, a Munson Health Care initiative, was launched in 1993 with funding from the US Department of Health and Human Services to set up a network of 12 health systems across the northern areas of the lower peninsula. REMEC provides a wide range of member services including voice, data, video bridging, community health education, continuing medical education, physician grand rounds, and telemedicine linkages statewide. In 2001, REMEC had over 40,000 participants involved in the 1,500 events broadcast through the network.

Through a **consortium of Marquette General Health System, Baraga County Memorial Hospital and Ontonagon Memorial Hospital**, diabetic patients in the UP receive services directly to their home via telemedicine as well as interactive specialty education and support group activities delivered to Baraga and Ontonagon Counties.

The **Veterans Administration Medical Center in Iron Mountain, MI** provides a wide range of specialty services via telemedicine to veterans in northern Michigan, including telepathology, telepsychiatry, teleradiology and primary care.



### Exemplar Telemedicine Projects in Michigan

<b>Location</b>	<b>Contact Information</b>
Marquette General Health System/ Upper Peninsula Telehealth Network	Sally Davis Program Director, Telehealth sdavis@mgh.org
Beaver Island Rural Health Clinic	Susan Meis, P.A. wisemeis@aol.com
LifeWays, in Partnership with Michigan State University	Pamela Whitten, PhD Principal Investigator pwhitten@msu.edu
University of Michigan Telemedicine Resource Center	Rashid Bashshur, PhD Telemedicine Resource Center bashshur@med.umich.edu
Michigan Dept. of Corrections	Lynette Holloway Telehealth Coordinator HOLLOWJ2state.mi.us
Hospice of Michigan, in Partnership with Michigan State University	Pamela Whitten, PhD Principal Investigator pwhitten@msu.edu
REMEC Telehealth Network	Dan Fly Director, REMEC dfly@mhc.net
Consortium of Marquette General Health System, Baraga County Memorial Hospital and Ontonagon Memorial Hospital	Sally Davis Program Director, Telehealth sdavis@mgh.org
VA Medical Center, Iron Mountain MI	Joseph Lerschen Program Officer, Clinical Support Services joseph.lerschen@va.med.gov

## **V. Recommendations to Advance Telemedicine in Michigan**

This section sets forth the recommendations of the Working Group on Telemedicine Policy for Michigan.

### **A. Coordination Mechanism**

The Working Group recommends that a mechanism be established to facilitate implementation of the recommendations set forth below. Ideally a non-partisan, not-for-profit organization (that is not in competition for healthcare dollars) would act as a liaison in helping to form the various groups of experts and leaders described below, and to coordinate their activities. This facilitating organization needs to have expertise, infrastructure and a mission consistent with the advancement of statewide health advancements. Seed money for this function should be appropriated and administered by an appropriate state agency. In order to facilitate the coordination of these tasks, resources costing approximately \$75,000 will be needed to cover a small percentage of time for administrator, salary for .5FTE coordinator, and overhead expenses such as office, phones, etc for a 15-month period.

## **B. Licensure, Certification, and Credentials**

### **1. Issues Presented**

A provider who employs telemedicine technologies to diagnose or prescribe treatment for a patient physically located across state and/or international borders may legally be considered to be practicing medicine in that foreign jurisdiction, and therefore may need a license there. This means that:

- Michigan providers may be unable to render telemedicine services to patients located in at least some states or nations outside of Michigan. Michigan providers in nationally prominent centers and/or in border communities may be affected most acutely.
- Michigan residents may be unable to receive telemedicine care from their Michigan provider if the patient or provider is temporarily outside the state. This is particularly significant given that many Michigan residents, especially elderly residents, spend the winter months in warmer climates.
- Michigan residents may also be unable to receive telemedicine care from sub-specialists or providers who treated them elsewhere if the physician is licensed in another jurisdiction only.
- Uncertainty about the current state of the law may have a chilling effect upon the diffusion of telemedicine services.

Most important to consider are issues related to patient safety. It is vital that informed decision makers weigh the consequences of imposing full, partial, reciprocal

licensing legislation or no action at all in regard to ensuring the highest caliber of safe medical care for residents of Michigan.

## **2. Recommendations**

The working group recommends continued short-term adoption of the 1996 Federation of State Medical Board's Ad Hoc Committee on Telemedicine Model Act. In addition, to proactively address additional future issues, the working group recommends appointment of a task force to further study this issue, explore the potential for establishing provider licensure reciprocity with neighboring states for telemedicine, and, if necessary, to draft precise statutory language that would clarify the state of the law.

Some issues to be considered would include:

- The frequency or regularity with which the telemedicine care is rendered.
- Whether the care is rendered in conjunction with another provider who is licensed in the locality where the patient is physically located.
- Whether the care is rendered in a JCAHO-accredited facility.
- The availability of similarly qualified providers in the locality where the patient is physically located.
- Whether a prior provider-patient relationship existed.
- The provider has passed a nationally recognized examination.
- The experience of other states that have reciprocity.
- Whether it is advisable for Michigan to join the Interstate Nurse Licensure Compact.

An appropriate state agency would appear a logical candidate to coordinate and oversee the activities of this task force. Such a task force would benefit from

representation from referral centers, border communities, rural health providers, and health care administrators. Other organizations, such as the Michigan State Medical Society, the Michigan Peer Review Organization, The Bureau of Health Services, the Michigan Attorney General's Office, the Michigan Board of Medicine, the Michigan Board of Osteopathic Medicine, and the Michigan Board of Nursing should also be contacted for their potential input and expertise.

A reasonable time-line for this course of action would be as follows:

- April, 2002: Appointment of Task Force on Licensure for Provision of Telemedicine Across State and International Borders.
- March, 2003: Task Force reports its findings and recommends legislation and/or other action.

The Working Group does not recommend that special certification beyond professional licensure be required to render telecare. The consensus amongst the Working Group is that the training and experience necessary for licensure more than adequately prepares providers for telecare.

With respect to credentials, this is a matter largely controlled by the JCAHO. No recommendation for action by the State of Michigan is offered at this time.

## **C. Payment and Reimbursement**

### **1. Issue Presented**

Lack of reimbursement impedes the deployment of telemedicine services in many places. Although grants have made initiation of pilot telemedicine projects possible in some areas of Michigan, reimbursement is necessary for telemedicine to become viable on a widespread basis over the long-term.

### **2. Recommendations**

The working group recommends that Michigan consider adding telemedicine consultations to the list of services reimbursed under Medicaid. The process would begin with an analysis by Michigan Department of Community Health, Medical Services Administration, (MDCHMSA) of what telecare services, by CPT code, are actually being rendered to patients in Michigan and comparing them against the list of CPT codes currently eligible for Medicaid reimbursement. Next, MDCHMSA would do an analysis of the anticipated costs to the State of reimbursing telecare providers for such services. These costs figures would then be reported to the Michigan Department of Management and Budget. If approved, these expenditures would be added to the budget the Governor submits to the Legislature. The organization developed as a coordinating mechanism should provide facilitation and record keeping support for this activity.

With respect to the issue of reimbursement by private insurers for telecare, the working group recommends formation of a consortium of parties interested in telemedicine services in Michigan. A priority of this consortium should be to determine criteria and guidelines for a reasonable telecare reimbursement policy. Such a policy needs to give due regard to insurer concerns about potential over-utilization, fraud, and

abuse. This consortium should also render a recommendation as to whether it is appropriate and/or advisable for Michigan to prohibit health insurers from unreasonably refusing to reimburse for telemedicine consultations.

An appropriately identified state agency would appear a logical candidate to coordinate and oversee the activities of this consortium. Such a consortium should include providers, health system administrators, health insurers, and consumer advocates. Other organizations, such as the Michigan Attorney General's office, the Michigan State Medical Society and Michigan Peer Review Organization might also have special expertise to lend.

A reasonable time-line for this course of action would be as follows:

- April, 2002: Appointment of Consortium on Private Insurance and Telemedicine Reimbursement.
- March, 2003: Consortium reports findings and recommended legislation to address reimbursement by private insurers of telemedicine providers.

## **D. Liability**

### **1. Issue Presented**

Liability in this context means the exposure of a healthcare provider to a claim for monetary damages for alleged medical malpractice while rendering telemedicine services. In many cases, telemedicine services may be equal to care provided in person. Some providers are concerned that there may be other circumstances where in-person treatment is superior to telemedicine. In these cases, there may still be some instances where diagnosis/treatment via telemedicine is far better than no diagnosis/treatment at all, but not as good as a face-to-face consultation would be, were the latter possible. Under such circumstances, the physician rendering telecare may inherently be unable to render care that rises to the standard of care reasonably expected in an in-person encounter, however, the exigencies of the situation may require that the patient receive telemedicine care immediately.

At present, there is uncertainty as to whether the trier-of-fact in a claim for malpractice would be allowed to take these factors into consideration. This uncertainty may have a chilling effect upon healthcare providers, causing many to be reluctant to render telemedicine services for fear of being held to an unreasonably high standard of care under the circumstances. The standard of care for telemedicine needs to be flexible enough for the trier-of-fact to be able to evaluate, on a case-by-case basis, both the decision to render care via telemedicine and the actual delivery of such care.



## 2. Recommendations

The working group recommends that a task force be appointed to further study this issue and determine if an legislation is warranted for this issue. If the task force concludes that legislation would be helpful, it should draft proposed legislation. Such legislation should allow the trier-of-fact to take into account such factors as:

- The location and condition of the patient
- The location and qualifications of the provider
- The nature of the services rendered
- The limitations of the technology employed
- Exigencies such as: weather, time of day, and the availability of face-to-face services.
- Such legislation might also seek to clarify issues of jurisdiction and venue for telecare cases.

An appropriate state agency would be logical to lead in the appointment and oversight of such a task force. Such a task force would benefit from participation from attorneys experienced in the prosecution and defense of healthcare liability litigation, as well as liability carriers, consumer advocates and provider representatives.

A reasonable time-line for this course of action would be as follows:

- April, 2002: Appointment of task force on Appropriate Standards of Care for Telemedicine Providers.
- March, 2003: Task force reports findings and recommended legislation to address standards of care for telemedicine providers.

The working group further believes that efforts to provide education concerning telemedicine, directed at medical and nursing students, as well as to practicing physicians and nurses, would serve the dual purposes of advancing Michigan's position as a leader in health education, while simultaneously reducing liability exposure. The Working Group recommends the formation of a consortium of the state's medical and nursing schools to develop curriculum for telemedicine education. This unfunded initiative would be performed by the coordinating arm for this project.

## **E. Infrastructure**

### **1. Issue Presented**

Lack of high-speed Internet access at an affordable cost impedes the diffusion of telemedicine in Michigan. The Michigan Economic Development Council (MEDC) recently issued a report and recommendations concerning the improvement of information infrastructure in Michigan.

According to MEDC, the first step in enhancing Michigan's information infrastructure is assessment of the networks and facilities that are currently in place. This step is now underway under the direction of MEDC.

### **2. Recommendations**

The Working Group believes that telemedicine should be viewed as one important component of a coordinated effort to improve Michigan's information infrastructure. A mechanism is needed for determining the need for and availability of information services to health care providers. Health care providers need to be included with those public users of communication services whose purchases are aggregated for competitive bidding. Health providers need greater access to bandwidth for telecare but also for more mundane tasks such as transmission of records, claims submission, medical education and informatics generally.

The working group believes the health perspective should be incorporated into MEDC's current efforts, rather than duplicating the state-funded work being conducted by MEDC to assess the telecommunication infrastructure in the state. It is vital that

MEDC incorporate the health perspective into its regional and community-based initiatives.

The working group does not recommend legislation to specifically address the infrastructure needs for telemedicine at this time. Instead, the working group recommends a formal liaison with MEDC's efforts in this area.

## **F. Privacy, Security and Confidentiality**

### **1. Issue Presented**

HIPAA has led to regulations concerning the privacy, security and confidentiality of patient records. These regulations took effect April 14, 2001. Healthcare providers throughout the nation are required to be HIPAA-compliant by April 14, 2003. HIPAA provides that these new federal guidelines are the minimum safeguards permissible in the United States; if any individual state requires even more stringent patient record safeguards, HIPAA provides that the higher state standards apply.

### **2. Recommendations**

The Working Group makes no recommendation as to whether Michigan should undertake to enact safeguards that go beyond the requirements of HIPAA at this time. The Michigan Attorney General has recommended additional requirements concerning the privacy of patient records. House Bill 4936, which would implement those recommendations, is currently pending. In addition, there appear to be several efforts underway to develop information and guidelines for Michigan providers to become HIPAA compliant. The Health Law Section of the State Bar appears to be one group already active in this pursuit.

The Working Group recommends that the coordinating entity described in Section V-A above undertake to determine, summarize and disseminate what HIPAA-compliance activities are already underway in Michigan. Rather than duplicating those efforts, the task would then become to ensure that the efforts already underway include consideration of the challenges presented to telecare providers and their patients. In addition, the

coordinating entity would facilitate an unfounded, voluntary group of health providers around the state to share compliance strategies with the goal of maximizing HIPAA compliance throughout Michigan.

## VI. Summary

<b>Barrier</b>	<b>Recommendation(s)</b>
Licensure	Create task force to make recommendations that will clarify licensure laws for telecare; consider Interstate Nursing Licensure Compact. Do not require certification for telecare.
Payment & Reimbursement	Perform analysis to consider adding telecare CPT codes to the list of services covered by Medicaid. Create consortium to recommend reasonable guidelines for private insurers' treatment of telecare services.
Liability	Create task force to consider liability issues presented by telecare. Create working group to add telecare to health education curricula for professionals and students in Michigan.
Infrastructure	Include telecare and health providers as a component of the infrastructure improvement efforts of MEDC.
Privacy, Security, and Confidentiality	Do not initiate new security measures. Ensure that the many HIPAA and medical records confidentiality efforts already underway give due consideration to telecare. Disseminate current state efforts to health providers in Michigan.
Coordination of activities to address each of the five barriers	Fund a 15-month, neutral coordinating entity to facilitate activities and document progress.

## **VII. Conclusion**

The benefits that Michiganders now enjoy from telemedicine are hopefully just a small step toward what is yet to come. Telemedicine applications offer the promise of improved access to care and tremendous cost savings. Telemedicine can improve, and in some cases even save countless lives in Michigan by transcending barriers of time and space between healthcare providers and patients in need. By enhancing the efficiency and efficacy of healthcare delivery, telemedicine also can potentially mitigate the expanding economic burden of providing care to an aging population. As technology advances, the telemedicine applications of the future will undoubtedly offer additional benefits we have yet to imagine. Leadership in telemedicine must be viewed as an essential component of Michigan's vision of becoming a leader in technology generally. Therefore it is vital to our state, economically and socially, to promote policies that enhance the diffusion of telemedicine applications in Michigan.

This report represents the work product of the first coordinated effort to identify, engage, and overcome policy barriers to the diffusion of telemedicine applications in Michigan. The Working Group identified five key policy barriers to the diffusion of telemedicine in Michigan, and offered several suggested steps toward alleviating them. The members of the Working Group deserve thanks and praise for their valuable contributions toward these ends.

However, this effort must be regarded as merely a beginning. Vision, without follow-through, will not accomplish the goal. The policy barriers described herein are substantial and require action. Unnecessary delay will only cause Michigan to fall further behind other states in the advancement of telemedicine. Michigan seeks to become a



national leader in the information technology field. Leading the nation in telemedicine activities will only serve to enhance our reputation.

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Table 1. Roster of the Working Group on Telemedicine Policy for Michigan

Laura Appel Michigan Hospital Association	Susan Makela, RN, BSN, MPA Oat Grant Director, Telehealth Marquette General Health Systems
Denise Chrysler, Assistant Attorney General Community Health Division Michigan Department of Attorney General	David Nerenz, Ph.D. Director Healthcare Studies Institute of Managed Care
Gerry Chase Northwest Community Mental Health	Michele Nypaver, M.D. Clinical Asst. II, Ped. & Comm. Diseases Dept. University of Michigan Medical School
Jan Coye, RN, Director Nursing Education & Practice Michigan Nurses Association	Thomas O'Keefe Administrative Fellow Spectrum Health
Sally Davis, Program Director Telehealth & Management Marquette General Health Systems	Eric W. Ott Internet Sales Specialist IP Security, SBC
Robert Filka Vice President of Strategic Initiatives Michigan Economic Development Corporation	Jeanne Parzuchowski Vice-President of Research Hospice of Michigan
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Steve Levine, M.D. Wayne State University School of Medicine	Michael Thompson Quality Management Director LifeWays
Curtis Levinson CDP, CISSP Professional Services Manager SBC DataComm	Walter Wheeler, Chief Department of Consumer Industry Bureau of Health Systems
Thomas Lindsay, Chief Department of Consumer & Industry Bureau of Health Services	Pamela Whitten, Ph.D. Associate Professor Michigan State University

Table 2. Telemedicine-Related State Licensure Laws

Source: Center for Telemedicine Law, "Quarterly Telemedicine Licensure Update," Vol.2, No.3, June 2000

1. Alabama Code §§ 34-24-502,503,507 (1997).
  - Special licensure for out-of-state physicians
2. Ark. Code Ann. § 17-95-206 (1997). Arkansas Session Law 220 (1999)
  - Full licensure for out-of-state physicians (1997)
  - Nurse Licensure Compact (1999)
3. California Business and Professional Code §§ 2060,2290.5,2052.5 (1997).
  - Registration program for telemedicine providers created by Board of Medicine
4. Colorado Rev. Statute Ann § 12-36-106 (1998). SB 19 62nd Legislature (1999)
  - Full licensure for out-of state physicians
  - Limited license for physicians affiliated with Shriners Hospital for Children (1999)
5. Connecticut General Statute § 20-9 (1997).
  - Full licensure for out-of-state physicians
6. Delaware HB 439 (1999)
  - Interstate Nurse Licensure Compact (2000)
7. Georgia Code Ann. § 43-34-31.1 (1998).
  - Full licensure for out-of-state physicians
8. Hawaii Rev. Statute § 453-2 (1997). SB 1136 (1999)
  - Permits out-of-state physicians without in-state offices to practice telemedicine
  - State licensure not required if out-of-state physician is providing consultation to an in-state licensed physician (1999)
9. 225 Illinois Comp. Statute 60-49.5 (West 1998).
  - Full licensure for telemedicine practitioner

10. Indiana Code Ann. § 25-22.5-1-1.1 (Michie1998).
  - Full licensure to practice telemedicine
11. Iowa HF 2105 (3/2000)
  - Interstate Nurse Licensure Compact
12. Kansas Administrative Regulations § 100-26-1 (1996).
  - Full licensure for out-of-state physicians
13. Maine ME LD 2558 (2000).
  - Interstate Nurse Licensure Compact
14. Maryland SB 490 (1999)
  - Interstate Nurse Licensure Compact
15. Mississippi Code Ann. § 73-25-34 (1997). MS HB 535 (2000)
  - Full licensure for out-of state physicians practicing telemedicine
  - Interstate Nurse Licensure Compact
16. Montana HB 399, 56th Legislature (1999)
  - Telemedicine certificate issued by Board of Medical Examiners.
17. Nebraska Rev. Statute § 71-1,102 (1998). NE L.B. 523 (1999).
  - Full licensure for out-of-state physicians
  - Interstate Nurse Licensure Compact effective 7/1/2000
18. Nevada Rev. Stat. Ann. § 630-020- (Michie 1997). Nev. Rev. Stat. Ann. tit. 54 ' 630.020 (2000).
  - Full licensure for out-of-state physicians practicing telemedicine
  - Exemption for physicians called into the state by a licensed in-state physician for a consultation on an irregular basis.
19. New Hampshire SB 53 (1999)
  - Full licensure for out-of-state physicians providing contractual or frequent teleradiology service to NH patients.

20. North Carolina General Statute § 90-18 (1997). N.C. Sess. Law 1999-0245 '90-171.80 - 171.93 (1999)
  - Full licensure for out-of-state physicians.
  - Interstate Nurse Licensure Compact (effective 7/1/2000)
21. North Dakota HB 1158 (1999)
  - Full licensure required unless out-of-state physician is in consultation with in-state licensed physician physically located in ND and primarily responsible for the care of patient.
22. Oklahoma Statute title 36, § 6802(1997)
  - Full licensure for out-of-state physicians
23. Oregon SB 600 (1999)
  - Special purpose telemedicine license for out-of-state physicians. Allows consultations and emergency care without license.
24. South Dakota Codified Laws § 36-4-41- (Michie 1998) SD H.B. 1045 (2000).
  - Full licensure for out-of-state physicians, using electronic means to treat persons located in SD.
  - Interstate Nurse Licensure Compact, effective 1/1/2001.
25. Tennessee Code Ann. § 63-6-201 (1998), Tenn. Comp.R.& Regulations Chap 0880-21.16 (1998)
  - Special purpose license for out-of-state physicians.
26. Texas Rev. Civ. Stat. Art. 4495b, §3.06 (I) (1998), 22 Tex. Admin. Code §§ 174.1-174.15 / HB 1342, 76th Legislature (1999)
  - Special purpose license for telemedicine practitioners (1998)
  - Interstate Nurse Licensure Compact, enacted 6/19/99
27. Utah Code Ann. § 58-31b-102 (1998), Utah Code Ann § 58-1-307 (1998), SB 26 (1999)
  - Full licensure for out-of-state physicians
  - Interstate Nurse licensure compact, effective 1/1/2000
28. West Virginia HB 2082, 74th Legislature, (1999)
  - State licensure for the practice of telemedicine with some consultation exceptions.



29. Washington WI A.B. 305 (1999).

- Interstate Nurses Licensure Compact effective 1/1/2000
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30. Wyoming Rules 024-052-001 § 4(d) (1998)

- Full licensure for out-of-state physicians

Table 3. States that Adopted the Interstate Nurse Licensure Compact.

Arkansas, Delaware, Iowa, Maine, Maryland, Mississippi, Nebraska, North Carolina, South Dakota, Texas, Utah and Wisconsin

Source: Office for the Advancement of Telehealth, 2001 Report to Congress on Telemedicine,

Available HTTP: <http://telehealth.hrsa.gov/pubs/report2001/legaltxt.htm>

Table 4. States Where Medicaid Reimbursement of Services Utilizing Telemedicine is Available.

Arkansas:

The Medicaid Agency recognizes physician consultations when furnished using interactive video teleconferencing

Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for the telemedicine services.

The state uses specific codes to identify telemedicine services. The state contact is Will Taylor (501) 682-8362.

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California:

The Medicaid Agency recognizes physician consultations (medical & mental health) when furnished using interactive video teleconferencing.

Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for telemedicine services.

The state uses consultative CPT codes with the modifier "TM" to identify telemedicine services. The state contact is Dr. Michael Farber (916) 657-0548.

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Georgia:

The Medicaid Agency recognizes physician consultations when furnished using interactive video teleconferencing.

Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for telemedicine services.

The State uses specific local codes to identify the consultation furnished at the hub site. No special codes or modifier is used at the spoke site. The State contact is Sherley Benson (404) 657-7213.

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Illinois:

The Medicaid agency recognizes physician consultations when furnished using interactive video teleconferencing.

Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional face-to face manner. Reimbursement is made at both ends (hub and spoke sites) for telemedicine services.

The state uses specific codes to identify telemedicine services. The state contact is R. Calluza or Maryann Daily at (217) 782-2570.

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#### Iowa:

The Medicaid Agency recognizes physician consultations when furnished using interactive video conferencing.

Payment is based on the State's fee-for-service rates for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for telemedicine services.

Specific local codes are used for the add-on payment and CPT codes with the modifier "TM" is used to identify the consultations. The State contact is Marty Swartz (515) 281-5147.

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#### Kansas:

The Medicaid Agency recognizes home health care and mental health services already covered by the state plan when furnished using video equipment. Home health is limited to certain services.

Payment is on a fee-for-service basis for the mental health services, which is the same as the reimbursement for covered services furnished in the conventional manner. Compensation for home health care via telemedicine is made at a reduced rate. Reimbursement is made for only the service furnished at the hub site.

Local codes have been established to specifically identify home health services furnished using visual communication equipment. No special modifiers are used for mental health services. The State contact is Ms. Fran Seymour-Hunter - (785) 296-3386.

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#### Louisiana:

The Medicaid agency recognizes physician consultations when furnished using interactive video conferencing.

Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face to face manner. Reimbursement is made at both ends (hub and spoke site) for the telemedicine services. Physician Assistants are allowed to perform the service using telemedicine if they are authorized by a primary physician, which is the only one that is authorized to bill.

The State uses consultative CPT codes. The State contact is Ms. Kandice McDaniels (504) 342-3891, E-mail: [Kmcदानie@dhhmail.dhh.state.la.us](mailto:Kmcदानie@dhhmail.dhh.state.la.us).

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#### Minnesota:

The Medicaid agency recognizes physician consultations (medical and mental health) when furnished using interactive video or store-and-forward technology. Interactive video consultations may be billed when there is no physician present in the emergency room, if the nursing staff requests a consultation from a physician in a hub site. Coverage is limited to three consultations per beneficiary per calendar week.

Payment is on a fee-for-service basis, using the same payment rate as for covered services furnished in a conventional, face-to-face manner. Payment is made at both the hub and spoke sites. No payment is made for transmission fees.

Minnesota uses consultation CPT codes with the modifier "CT" for interactive video services and the modifier "WT" for consultations provided through store-and-forward technology. Emergency room CPT codes are used with a "GT" modifier for interactive video consultations done between emergency rooms. The State contact is Christine Reisdorf (651) 296-8822.

Note: Unless legislatively extended, telemedicine consultations are eligible for Medicaid payment only until June 30, 2001.

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#### Montana:

The Medicaid Agency recognizes any medical or psychiatric service already covered by the state plan when furnished using interactive video teleconferencing.

Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for the telemedicine service.

No special codes have been developed. Providers use codes from the existing CPT. State contact is Dave Thorsen (406) 444-3634.

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#### Nebraska:

The Medicaid agency recognizes most State plan services when furnished using interactive video teleconferencing. In general, services are covered so long as a comparable service is not available to a client within a 30-mile radius of his or her home. Services specifically excluded include medical equipment and supplies; orthotics and prosthetics; personal care aide services; pharmacy services; medical transportation services; and mental health and substance abuse services and home and community-based waiver services provided by persons who do not meet practitioner standards for coverage.

Payment is on a fee-for-service basis, which is the same as reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both the hub and spoke sites. Payment for transmission costs are set at the lower of the billed charge or the state's maximum allowable amount.

Billing and coding requirements will vary depending on who bills for the service and which claim form is used. The state contact is Dr. Chris Wright (402) 471-9136.

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#### North Carolina:

The Medicaid agency recognizes initial, follow-up or confirming consultations in hospitals and outpatient facilities when furnished using real-time interactive video teleconferencing. The patient must be present during the teleconsultation.

Payment is on a fee-for-service basis. The consulting practitioner at the hub site receives 75 percent of the fee schedule amount for the consultation code. The referring practitioner at the spoke site receives 25 percent of the applicable fee.

Teleconsultations are billed with modifiers to identify which portion of the teleconsult visit is billed; ie., the consulting practitioner at the hub site uses a GT modifier and the referring practitioner at the spoke site uses a YS modifier. The State contact is Janet Tudor (919)-857-4049.

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#### North Dakota:

The Medicaid Agency recognizes speciality physician consultations when furnished using interactive video teleconferencing.

Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for the telemedicine services.

Current CPT codes for consultative services are used with a "TM" modifier to specifically identify covered services which are furnished by using audio visual communication equipment. State contact is David Zetner (701) 328-3194.

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#### Oklahoma:

The Medicaid agency recognizes physician consultations when furnished using interactive video teleconferencing.

Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face to face manner. Reimbursement is made at both ends (hub and spoke site) for the telemedicine services.

The State uses consultative CPT codes. The State contact is Ms. Nelda Paden (405) 530-3398, E-mail: [Padenn@ohca.state.ok.us](mailto:Padenn@ohca.state.ok.us).

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South Dakota:

The Medicaid Agency recognizes physician consultations when furnished using (interactive & non-interactive) video equipment.

Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for the telemedicine services.

The state uses consultative CPT codes with a "TM" modifier to identify telemedicine services. The state contact is Linda Waldman (605) 773-3495.

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Texas:

The Medicaid agency recognizes physician consultations (teleconsultations) when furnished using interactive video teleconferencing.

Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face to face manner. Reimbursement is made at both ends (hub and spoke site) for the telemedicine services. Other health care providers, such as advanced nurse practitioners and certified nurse midwives are allowed to bill, as are Rural Health Clinics and Federally Qualified Health Centers".

The State uses consultative CPT codes with the modifier "TM" to identify telemedicine services. The State contact is Nora Cox Taylor, (512) 424-6669, E-mail: [nora.taylor@hpsc.state.tx.us](mailto:nora.taylor@hpsc.state.tx.us).

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Utah:

The Medicaid agency recognizes the following services when furnished using interactive video teleconferencing: mental health consultations provided by psychiatrists, psychologists, social workers, psychiatric registered nurses and certified marriage or family therapists; diabetes self management training provided by qualified registered nurses is made only to the consulting professional for mental health services. Payment is made for transmission fees.

The state uses CPT codes with GT and TR modifiers to identify telehealth services. The state contact is Mr. Blake Anderson (801) 538-9925.

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Virginia:

The Medicaid Agency recognizes, as a pilot project, medical and mental health services already covered by the state plan when furnished using interactive video teleconferencing.

Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for only medical services.

The state uses specific local codes to identify telemedicine services. The State contact is Jeff Nelson 804-371-8857.

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West Virginia:

The Medicaid Agency recognizes physician consultations when furnished using interactive video conferencing.

Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for the telemedicine services.

The state uses consultative CPT codes with the modifier "tv" to identify telemedicine services. The state contact is Laure L. Harbert (304) 926-1718.

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Source: HCFA

<http://www.hcfa.gov/medicaid/telelist.htm>



Table 5. Additional State Laws addressing Telemedicine

**Alabama**

Section. 34-24-5000

Creates a special purpose license for the practice of telemedicine by a medical doctor or osteopath

**Arizona**

Section 36-3602

Imposes certain informed consent and medical records requirements on providers of telemedicine.

**California**

Section 1374.13

Forbids private health insurers from requiring face-to-face contact as a pre-condition for reimbursement for medical services if medical services are appropriately rendered by telemedicine.

**Hawaii**

Section 431:10a-116.3

Forbids private health insurers from requiring face-to-face contact as a pre-condition for reimbursement for medical services if medical services are appropriately rendered by telemedicine.

**Kentucky**

Section 304.17a-138

Forbids private health insurers from requiring face-to-face contact as a pre-condition for reimbursement for medical services if medical services are appropriately rendered by telemedicine.

**Louisiana**

Section 22.657

Requires private insurers to reimburse telecare providers at least 75% of reasonable and customary amount.

**Montana**

Section 37-3-342 et. seq.

Creates special telemedicine certificate for out-of-state medical doctor or osteopath specialist to deliver telecare to patients in Montana.

**Oregon**

Section 677.139

Allows for reciprocal licensing of physicians licensed in other states.

**Tennessee**

Section 63-6-209

Allows for conditional licensure to out-of-state physicians for limited purpose of telemedicine.

**Texas**

Section 151.056

Exempts out-of-state specialists from licensure requirements for episodic rendition of telecare to patients in Texas.

Texas Insurance Code Article 21.53f

Prevents private insurers from excluding a benefit from coverage solely on the basis that the service was provided by telemedicine.

Source: Schanz, S.J., & Cepelewicz, B.B. (2001). Telemedicine Law & Practice.

Kingston, NJ: Civic Research Institute.