Telemedicine Clinical Advisory Group (TCAG)
August 18, 2011
Meeting Notes

Attendees in person
Robert Bass-MIEMSS, TCAG Chair, Barney Stern, U of Maryland, Anna Aycock-MIEMSS, E. F. Magee-MIEMSS, Pat Gainer-MIEMSS, Jennifer Witten-American Heart & Stroke Association, Sarah Orth-Maryland Health Care Commission, Michelle Clark-Maryland Rural Health Association, Laura Pimentel-ACEP, Stephen Michaels-St. Mary's Hospital/Medstar, Marc Zubrow-eCare, Neal Reynolds –STC/MEDCHI, Laura Pimentel-ACEP, Patty Ciata-CareFirst/Government Affairs, Gary Capistrant-American telemedicine Association, Virginia Rowthorn, Managing Director, Law & Health Care Program Lecturer in Law and Director, Health Law Externship Program University of Maryland Francis King Carey School of Law

Attendees via teleconference
Jo Wilson-Western Maryland Health System, Salliann Alborn-Community Health Integrated Partnerships, Mimi Novello-Medstar Health, Michael Franklin–Atlantic General Hospital, Amjad Riar, Governor's Commission on Asian Pacific American Affairs, Eric Stoddard–U of M CHHS, Michelle Hardy-Wicomico County Health Department, Dan Winn-CareFirst, Karen Rezabek-MHCC, Christina Shaklee-DHMH, Tricia Handel-Board of Physicians, Gary Capistrant-American telemedicine Association, Peggy Naleppa-PRMC, David Winn-CareFirst, Leo Chalmers-CareFirst, Claudia Baquet- University of Maryland School of Medicine, Rich Colgan-UMB, David Finney-CRISP Consultant

Welcome & Introductions
Dr. Bass welcomed everyone and introductions were made.

TCAG Discussion Notes from 8/4/11
Meeting notes were approved as written for posting to the web site.

Telemedicine Use & Reimbursement: Claudia R. Baquet, MD, MPH
Dr. Baquet gave an overview of the 2006 University of Maryland School of Medicine Telemedicine-Use and Reimbursement Study including the Tele-Home Health Monitoring Pilot Project in Garrett County.(attached and posted on the web site: http://dhmh.maryland.gov/mhqcc/telemedicine.html)
The Tele-home Health Monitoring was a prospective observational cohort study of home monitoring for chronically ill patients with uncontrolled hypertension, diabetes, chronic heart failure and COPD. The aim of the pilot was to improve uncontrolled hypertension and diabetes rates, to decrease medical resource use in heart failure patients and COPD patients for emergency department visits, hospital admissions and to increase the quality of life for these patients. The three component Vidal Net system consisted of a Vidal Care home monitor installed in the patient's home by the home health nurse, a Vidal Net postmaster call center that was linked to the home health agency's command center and a Vidal Care web application. These captured the patients health measurement using serial ports connected to blood pressure cuffs etc. and transmitted to the home health agencies. The study was conducted during 2007 and 2008 with 22 patients enrolled. The hypertension group showed a dramatic improvement in systolic and diastolic blood pressure, the diabetes group showed a marked reduction in blood sugars, the COPD

group showed a significant reduction in emergency room visits and hospital admissions. This spring under the NIH Social Determinates of Health home health was expanded to Southern Maryland and Garrett County with a focus for CHF, hypertension, diabetes and COPD. The sample is larger than the pilot study and is progress.

Under Senate Bill 728 the 2006 Maryland Telemedicine Reimbursement Study team conducted interviews and analyzed the state of reimbursement at that time. There are restrictive federal guidelines for what is considered a rural area and what can be reimbursed in Maryland.

During this time period an organized collaboration was formed with the Eastern Shore for in service training that provide CE and CMEs. Funding has ended for that program.

Dr. Baquet stated that until the definitions or expansion of designation for Health Profession Shortage Areas (HPSAs) are changed Maryland will need to look for additional funding sources.

Dr. Stern asked Dr. Baquet, putting aside federal regulations and reimbursements, what would be her recommendation for a disease or symptom condition that would be a demonstration project for current generation telemedicine usage based on feasibility public health imperative. Dr. Baquet recommended home monitoring for patients with chronic diseases such as hypertension, diabetes, COPD and congestive heart.

Dr. Reynolds stated that Virginia recently passed legislation mandating parody payment of physician services whether it be distance or face to face. In the state of Virginia Medicaid pays mileage and Virginia noted that the Medicaid would save over 6 million miles of travel utilizing telemedicine. Dr. Reynolds asked if Maryland Medicaid paid mileage. Dr. Baquet state she did not know at this time but could find out.

Dr. Riar noted that in the CTeL report HRSA did not consider the savings in travel to offset the additional cost of reimbursement for telemedicine. (posted on the web site: http://dhmh.maryland.gov/mhqcc/telemedicine.html)

Dr. Bass asked if the Tele-home project included audio/video at the patient's home. Dr. Baquet advised that in the beginning of the pilot in Garrett County, audio/video was used, but was dropped within a year because it did not work in terms of clarity of picture and bandwidth issues

Dr. Bass thanked Dr. Baquet for her presentation and continued work in Telehealth/Telemedicine.

CareFirst Telemedicine Policy: Dr. David Winn, CareFirst Medical Director
Dr. Winn introduced CareFirst's Policy Director, Les Chalmers and gave an overview of CareFirst's Telemedicine policy via power point presentation (attached and posted on the web site: http://dhmh.maryland.gov/mhqcc/telemedicine.html)

Dr. Winn advised that the CareFirst policy has been in effect for approximately one month and is based on the Virginia legislation and is defined as a combination of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation or treatment.

The only way to bill for telemedicine services in 2011 is by using CPT ® codes with HCPCS modifier - GT appended, which indicates that the service was provided "via interactive audio &

video telecommunication systems." The reimbursement rate will be the same as a face to face patient encounter. The physician needs to be credentialed by CareFirst. CareFirst will not be reimbursing for any technical fees.

Dr. Pimentel asked, based on the current fee schedule, how CareFirst account for a physical examination using telemedicine. Dr. Winn advised that the services need to fall within the current coding system. It was noted that diagnostic codes may need to evolve and change to accommodate the unique billing of clinical telemedicine services.

Dr Bass inquired if both the nurse practitioner in the room with the patient and the specialty physician utilizing audio visual telemedicine would be reimbursed for services. Dr. Winn stated that the reimbursement would be no different than if the patient traveled the 100 miles to see the specialty physician the next week as long as the proper coding was used.

Dr. Stern noted that "time based billing" is pertinent to intensive care units consultations, the field of acute stroke / tele-stroke interventions, (validated studies in literature re: utility and reliability of the NIH Stroke Scale in the setting of the tele-stroke acute evaluation that is somewhat distinct in the traditional neurologic evaluation). Many of these telemedicine sessions are in a sense complex decision making cognitive encounters it may behoove all of us to consider a time based approach to get around the uniqueness of this scenario. Dr. Winn stated in trying to mirror the in person world; if there is time based codes that are traditionally reimbursed, there should be no reason the codes could not be used for telemedicine.

Dr. Zubrow asked if his tele Intensivists could now bill for tele-ICU consults. Dr. Winn stated if it is within policy and the traditional code requirements are met, it would now be reimbursable.

Ms. Orth asked what specialties Dr. Winn would envision utilizing telemedicine first. Dr. Winn stated it was so new that he is unsure, but, it will be interesting to see.

The consensus of the group is that billing codes will need to be changed to accommodate telemedicine services.

University of Maryland School of Law White Paper: Virginia Rowthorn, J.D.
Ms. Rowthorn gave a presentation via power point and discussion on the Legal Impediments to the Practice of Telemedicine. (attached and posted on the web site: http://dhmh.maryland.gov/mhqcc/telemedicine.html)

The burdensome and costly issue is multistate credentialing for telemedicine physicians. Private companies are now providing telemedicine licensing services to fill the gap. Although there are different models for licensure, most states require full licensure whether it is a face to face or telemedicine encounter. Physician to physician consult is not included. One of the ATA recommends an interstate collaboration model which requires the establishment of a national multi-state clearinghouse where out-of-state physicians can register with other states. (This model is currently used by a number of nursing boards across the country) Ms. Rowthorn suggested that the TCAG may want to consider a special purpose license for out of state physicians practicing telemedicine in Maryland. (the out of state physician cannot have a physical location in Maryland) Any model adopted on the state or federal level should encourage uniform licensure rules across

the United States and integration of licensure with national physician databases to ensure seamless and accurate licensing and policing of physicians.

On May 5, 2011 CMS published a rule (effective July 5, 2011) that allows a hospital to grant practice privileges to a Telehealth provider by accepting the distant-site facility's credentialing and privileging approvals for that provider. The final rule allows for arrangement between a Medicare hospital and distant site telemedicine entity. It was suggested that COMAR regulations be cross walked with the new CMS ruling on credentialing and privileging.

Dr. Michaels asked if Maryland Law would allow credentialing by proxy; Ms Rowthorn and Mr. Magee will investigate.
Dr. Zubrow stated that letters were sent to their eCare hospitals suggesting that the formalizing the letter of agreement and changing the hospital by-laws; 4 of the 6 hospitals are now in alignment with the CMS regulation.

Dr. Michaels further asked how to comingle the privileging issues from the origination and telemedicine sites.

Dr. Riar asked if there is a regulation defining telemedicine in Maryland. Mr. Magee stated that COMAR 10.32.05.02 - Telemedicine means the practice of medicine from a distance in which intervention and treatment decisions and recommendations are based on clinical data, documents, and information transmitted through telecommunications systems.

Dr. Handley advised that the Regulations state that you have to be licensed in Maryland. Ms. Rowthorn stated that there is nothing that states you cannot credential by proxy and that the TCAG may wish to ask for an opinion on this.

Ms. Rowthorn added that a sample written agreement can be found at: http://ctel.org/wp-content/uploads/2011/07/DRAFT-Credentialing-and -Privileging-Agreement-Between-Hospitals.pdf

Ms. Rowthorn advised there have been very few telemedicine malpractice cases. Hospitals may want to draft specific telemedicine informed consent forms to clarify that the patient knows where the doctor is and focus on the privacy concerns.

Dr. Reynolds asked if there were any legal precedents or opinions regarding archival of telemedicine interactions or any for informed consent for clinical study by telemedicine.
Ms. Rowthorn stated there are no cases of which she is aware.

A discussion ensued regarding what information would need to be stored for a telemedicine encounter i.e. the video encounter. Dr. Bass stated that the EMS consultations are recorded but are kept for quality assurance purposes not documentation purposes and destroyed after 180 days. Ms. Rowthorn stated that this could be an area for professional guidelines with industry standards. It was suggested that practice and professional guidelines for telemedicine need to be developed to potentially include the storage of data, imaging, and clinician duty hours.

Dr. Zubrow asked if telemedicine crosses state line would a malpractice case end up in federal court. Mr. Magee and Ms. Rowthorn advised that state law would apply depending on the state where the suit is filed.

Dr. Colgan noted that the Maryland Comprehensive Self Insured Trust at the University may be a good source of information. Dr. Reynolds, Dr. Stern and Dr. Zubrow all stated that they have not had any problems regarding malpractice with their telemedicine programs. Dr. Reynolds stated that he presented to the Maryland Comprehensive Self Insured Trust and it was indicated that it did not enhance liability.

Dr. Stern noted that the spirit of the law must recognize what is practical, professional and appropriate for an interaction.

Mr. Capistrant noted there will be specific legislation introduced in the Senate this fall for going to a National licensure format with state involvement in disciplining. It would be a voluntary arrangement; it will be unclear as to what will happen if a state opts out. There will most likely be incentives to participate. ATA has changed their opinion to go to a National model. This will be an area of increasing debate.

Dr. Stern stated that duty hours and patient safety needs to be explored regarding telemedicine i.e. should east coast specialist cover west coast specialists and vice versa during nighttime coverage. Dr. Pimentel mentioned that a Radiology group moved to New Zealand to provide telemedicine in the US at night. Dr. Zubrow stated that there is a telemedicine program in Arizona that utilizes Israeli specialists at night. Mr. Magee stated that there is a "Nighthawk Model" for telemedicine. www.nighthawkrad.net

Dr. Bass stated that a brief report will be presented to the Health Quality and Cost Council in a week or two and proposed to meet on September 15, 2011 at 2pm to regroup and decide on the proposals from the TCAG.

Dr. Bass asked Ms. Rowthorn to stay with the TCAG and work with Mr. Magee on legal issues.