LEGAL IMPEDIMENTS TO THE DISSEMINATION OF TELEMEDICINE

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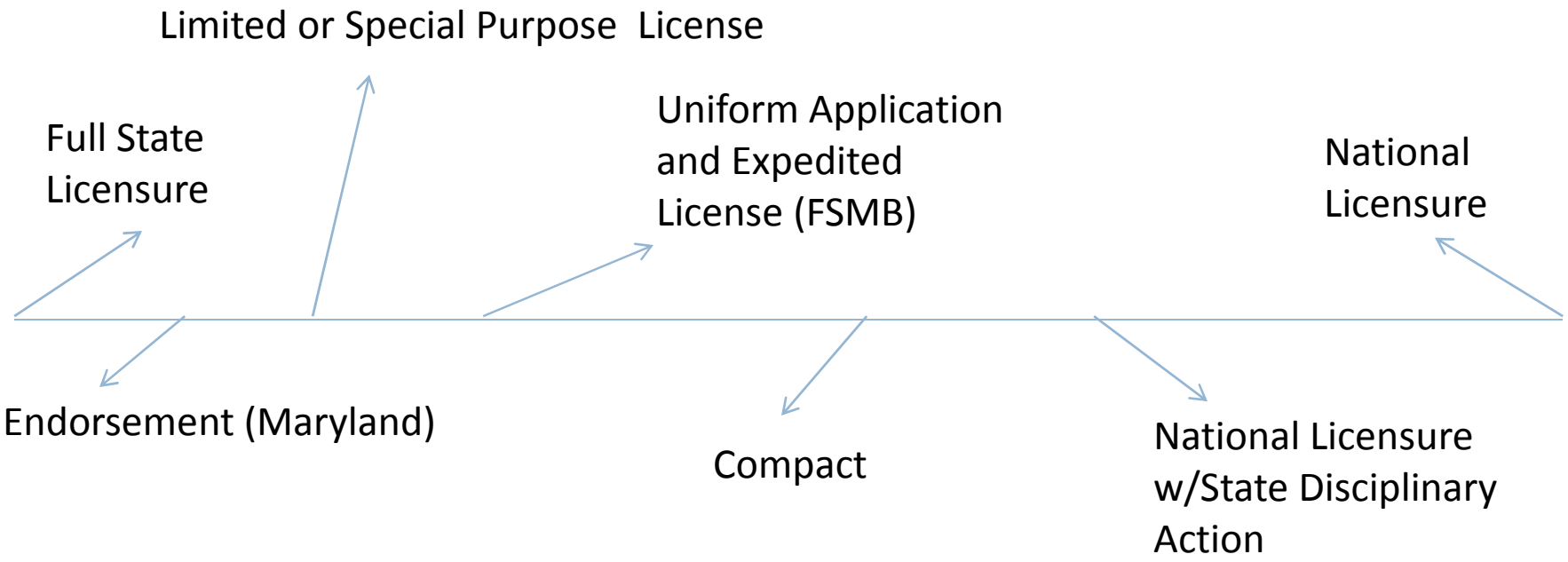
Legal Impediments – Focus Areas

- Physician licensure
- Credentialing and privileging
- medical malpractice and professional liability insurance

Physician Licensure

- What is the issue?
  - Every state has laws relating to the practice of medicine within that state's boundaries.
  - Those laws are enforced by state boards of medical licensure.
  - All medical boards perform essentially the same services **but have different administrative structures and rules**.
  - A telemedicine practitioner who practices in more than one state will need multiple licenses.

Licensure Models



Models of Licensure

- **Full state licensure (most states)**
  - An out-of-state physician cannot legally consult with, diagnose or treat a patient in that state without a full state license to practice medicine.
- **Endorsement**
  - A process whereby a state issues an unrestricted license to practice medicine to an individual who holds a valid and unrestricted license in another state that has equivalent standards (or requires additional qualifications or documentation before endorsing a license issued by another state).

Models of Licensure

- **Limited Licensure or Special Purpose License**
  - Originally promoted by FSMB. Lets a physician provide services to patients without opening an in-state office. The special purpose license is generally:
    - Based on a full and unrestricted license in another jurisdiction
    - Subjects the physician to the jurisdiction of the issuing state medical board and
    - Does not permit the licensee to physically practice in the other state.
  - However, this model raises concerns about singling out telemedicine as a unique specialty.

Models of Licensure

- **Uniform Application and Expedited License**
  - Currently endorsed by FSMB and supported by the FSMB Uniform Application. To qualify, the applicant must:
    - Be licensed in another jurisdiction,
    - Be free from discipline,
    - Have primary-source verified credentials, and
    - Demonstrate currency in training (i.e. ABMS specialty certification/maintenance of certification).
- **Compact**
  - Under this model
    - A physician has one license (in his or her state of residency) and is permitted to practice in other Compact states (both in person or remotely) subject to each state's practice laws and regulations.
    - Each participating state must adopt comparable authorizing legislation authorizing.
  - Adopted successfully by many boards of nursing in the United States.

Models of Licensure

- **National licensure models – two models:**
  - **Federalization of licensure**
    - A license would be issued based on a standardized set of criteria for the practice of healthcare throughout the United States.
    - Administration (including discipline) at the national level would be left to a national professional organization.
    - Such a model could apply to all aspects of licensing or could be limited to the practice of telemedicine.
  - **Hybrid model**
    - Would be implemented at the state level, requiring states voluntarily to incorporate the national standards into their laws. States would be unable to impose significant additional standards.
    - Health professionals would still be required to obtain a license from every jurisdiction in which they practice, but a common set of criteria would facilitate the administrative process.

Models of Licensure

- American Telemedicine Association (ATA) supports a two prong approach:
  - National preemption of state licensing laws for all physicians providing federally funded health services, i.e., services provided under Medicare and/or Medicaid.
  - Interstate collaboration model which requires the establishment of a national multi-state clearinghouse where out-of-state physicians can register with other states.
- Another model - situs of care – change law so that the practice of medicine takes place where the physician is located (instead of patient). Would require other states to make similar change in law.

Maryland Licensure Rules for Telemedicine Practitioners

- COMAR 10.32.05.01 and Md. Code Health Occ. §14-302
- Maryland follows the full state licensure model – specifically – if the patient or the physician is in Maryland, a full Maryland license is required.
- The **only exception** is for practice between Maryland and Washington DC (with which Maryland has equivalent laws and a reciprocal relationship).
- Licensure requirements apply where either the tele-medicine practitioner or patient are in Maryland.

Principles to Consider

- Any model adopted on the state or federal level should:
  - focus on the fundamental goals of licensure – to protect the public from incompetent physicians or sub-standard care;
  - be based on uniform licensure rules across the United States and integration of licensure with national databases;
  - not single out telemedicine as a special area of medical practice; and
  - rely on up-to-date national databases that are interoperable with electronic health records and other forms of medical information technology.

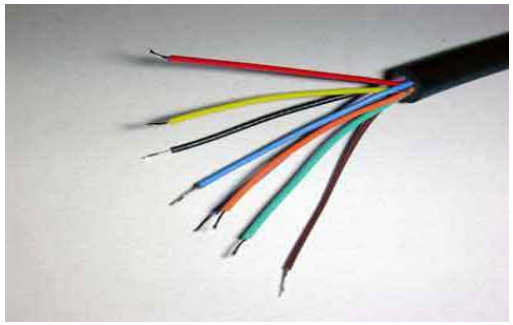
Credentialing and Privileging

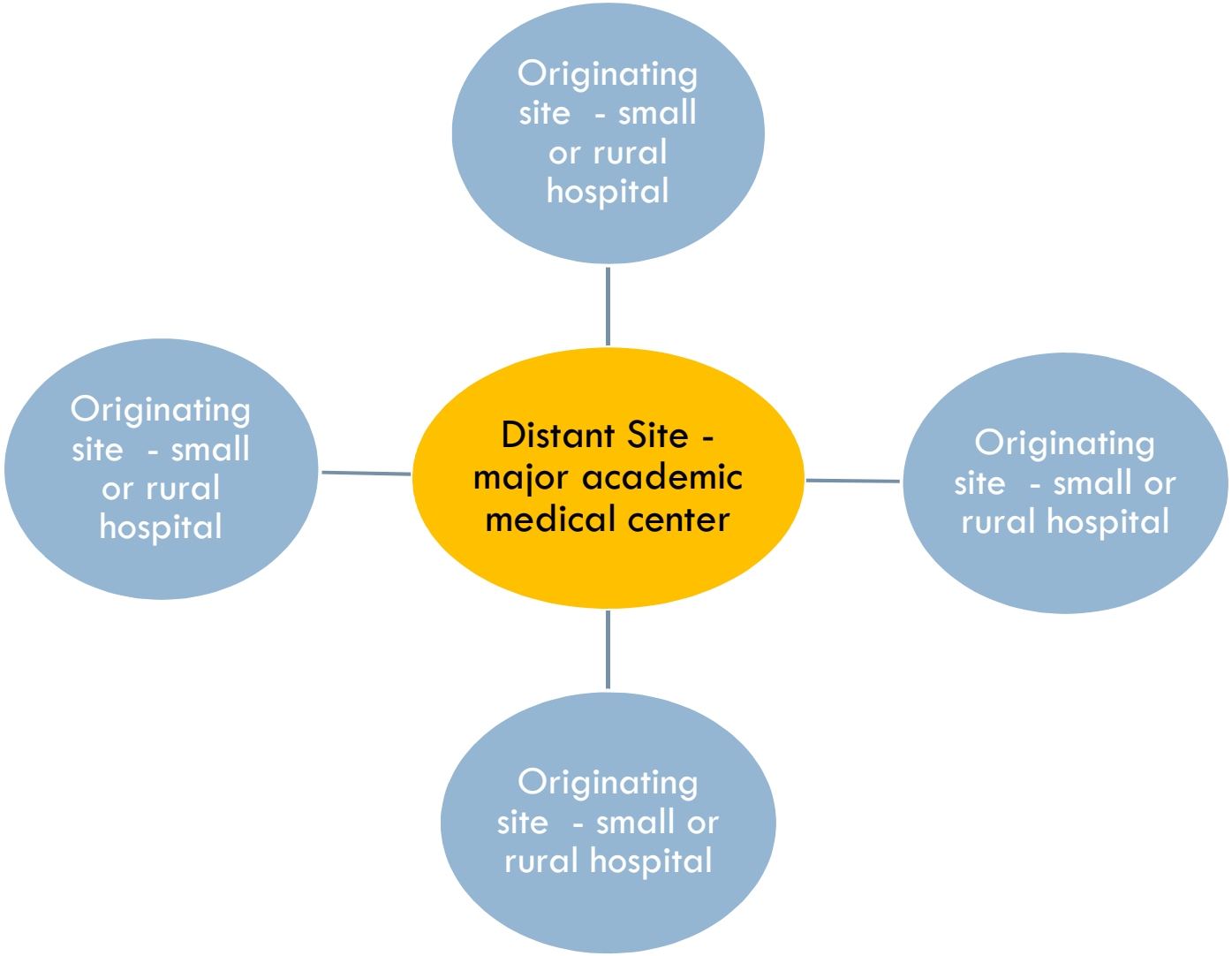
Credentialing

- Refers to the obtaining and reviewing the documentation of professional providers by a health plan. The documentation includes education, licensure, certifications, insurance, evidence of malpractice insurance and malpractice history.
- More objective.

Privileging

- The process whereby a specific scope and content of patient care services are authorized for a health care practitioner by a health care organization, on the basis of its evaluation of the individual's credentials and performance.
- Reprivileging – same process but heavily dependent on experience and competence shown since last privileging decision (usually 2 years prior).
- Decision based on peer review.
- More subjective





Which hospital is responsible for credentialing and privileging the practitioner – the originating site receiving the telemedicine consult or the distant cite giving the assistance?

Then . . .

- For years, the Joint Commission permitted "credentialing and privileging by proxy." This meant that the originating hospital could rely on the credentialing and privileging decisions of the distant JC accredited facility.
- Contrary to CMS Conditions of Participation that require all Medicare-eligible hospitals to credential and privilege all practitioners (whether telemedicine practitioners or not).
- In practice, many hospitals used Credentials Verification Organizations but did rely heavily on privileging by proxy.

Problem (late 2009)

- Medicare Improvements for Patients and Providers Act of 2008 removed the JC's statutorily granted accrediting authority as of July 15, 2010 and required all accrediting bodies, including the Joint Commission, to apply to CMS for hospital deeming authority.
- As part of this new application process, JC was required enforce the CMS requirements that all telemedicine practitioners must undergo credentialing and privileging at each originating site.

Concerns

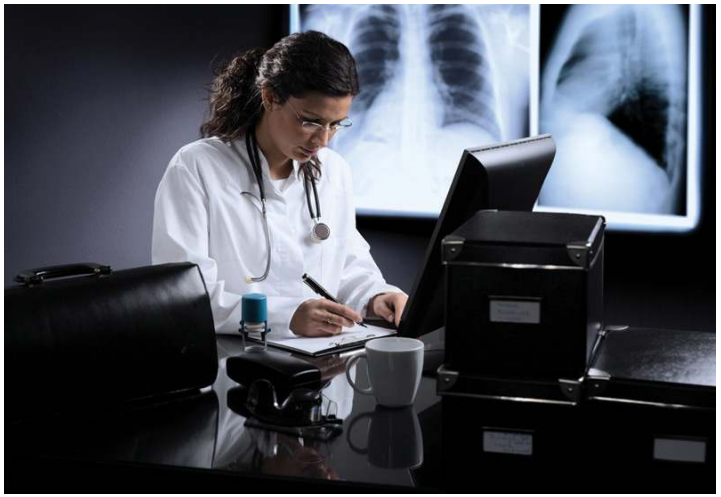
- If required to privilege all practitioners that provide telemedicine services, small hospitals might:
  - Choose not to use telemedicine because of the cost and administrative burden.
  - Privilege practitioners based on little or no background information about the actual qualifications of the practitioner.
- Physicians may not seek out telemedicine opportunities because of the administrative burden associated with becoming privileged in numerous sites and maintaining those privileges over time.

Now

- On May 26, 2010, CMS proposed new regulations in the *Federal Register* (FR Doc 2010-12627)
- The proposed rule change would allow a hospital to grant practice privileges to a telehealth provider at a second hospital by accepting the distant-site hospital's credentialing and privileging approvals for that provider.
- The proposed rule change requires that the provider be affiliated with the distant-site hospital, and have practice privileges there, and that both facilities be Medicare-participating hospitals.
- JC will allow privileging by proxy until final rule published.

Update

- Comments were due July 26 – CMS received about 100 – generally favorable.
- Comments will be published in late Spring and rule will become final 60 days later. Some minor changes to rule expected.



Going forward . . .

- Stand alone services (such as teleradiology)
  - Not covered by CMS rule (but accredited by JC under their ambulatory care rules).
  - Extend privileging rules required of hospitals by CMS to the stand alone services/ambulatory care facilities?
- Physician Licensure
  - According to CMS, the new rule is flexible enough to accommodate any changes made on state or federal level relating to licensure.

Going Forward . . .

- Protection of small hospitals that credential and privilege by proxy
  - Hospitals should not be pressured to accept more telemedicine services than they can handle or afford.
  - Hospitals should think about risk management and consider/clarify which hospital or entity is legally responsible for privileging decisions.
- Information sharing
  - Whichever entity is credentialing or privileging, complete information regarding a practitioner's practice history is critical and information sharing should be encouraged.

Medical Malpractice

- Too few telemedicine malpractice cases to draw ground rules about legal risks.
- Majority of legal actions to date brought against providers who prescribed medication over the internet (rather than claims against providers for negligent care administered through telemedicine).
- Widespread assumption that telemedicine poses additional liability risk may be unfounded (so far) but going forward, telemedicine may raise new questions in areas of jurisdiction, choice of law, duty of care concerns, and informed consent.

Medical Professional Liability Insurance

- Telemedicine may present unique challenges for MPL insurers in the following ways:
  - Litigation issues
  - Quality of medicine
  - Quality of technology
  - Training
- Physician Insurance Association of America is collecting data on telemedicine practice and associated liability claims and may respond if cases against telemedicine practitioners create additional burden on insurers.