



MARYLAND TELEMEDICINE TASK FORCE

INTERIM REPORT

December 2013

Prepared for
the Governor of the State of Maryland,
Senate Finance Committee,
and House Health and Government Operations Committee

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Overview

Telemedicine adoption is fragmented in Maryland. Diffusion of the technology in acute care hospitals is about 46 percent as opposed to roughly 10 percent among physicians.^{1, 2} Existing law requires State-regulated payors to reimburse for telemedicine services when certain conditions are met.^{3, 4} In general, providers have been slow to take advantage of the law. Over the last nine months, only about 50 providers submitted roughly 78 telemedicine claims to State-regulated payors.⁵ In comparison, government payors limit telemedicine reimbursement. Medicare provides reimbursement for about 60 evaluation and management services within certain rural areas of the State. Medicaid reimbursement is restricted to two pilot programs.⁶

Existing fee-for-service models incentivize episodic care and do not provide incentives for the investment in new models of care delivery. The Patient Protection and Affordable Care Act (ACA) fosters innovative care delivery models that incentivize providers to improve quality and efficiency of health care based on patient outcomes rather than volume of services provided. The use of telemedicine can support innovative care delivery models by improving health care quality and patient outcomes while reducing cost. Despite the potential of telemedicine to enhance the way care is delivered, it is not expected to increase significantly absent widespread adoption of value-based care.

State law requires the Maryland Health Care Commission (MHCC) to reconvene the Telemedicine Task Force (task force) to identify opportunities for expanding telemedicine to improve health status and care delivery.^{7, 8} The law also requires MHCC to update the Governor, Senate Finance Committee, and the House Health and Government Operations Committee on the work of the task force by the end of 2013. This is an interim report on the work of the task force; the final report

¹ Maryland Health Care Commission, *Health Information Technology: An Assessment of Maryland Hospitals*, September 2013. Available at:

http://mhcc.dhmh.maryland.gov/hit/Documents/2013_hospital_health_it_assessment.pdf.

² 2012 Board of Physician Licensure file, a database of physician responses to the bi-annual licensure survey.

³ Md. Code Ann., Insurance § 15–139. See Appendix H.

⁴ For more information on State laws related to reimbursement, see the American Telemedicine Association, *State Telemedicine Legislation Tracking*, 2013 in Appendix D.

⁵ The largest four State-regulated payors reported roughly 78 claims were submitted for services rendered through telemedicine from the time the law was enacted on October 1, 2012 through June 30, 2013. State-regulated payors indicated that it is possible that providers are rendering services through telemedicine and are not using the modifier in claims submission.

⁶ The Maryland Department of Health and Mental Hygiene's Medical Assistance (Medicaid) Program launched two programs - the Rural Access Telemedicine Program and the Cardiovascular Disease and Stroke Telemedicine Program - to improve participant access to consulting Medicaid providers when an appropriate specialist is not available to provide a timely consultation. The new programs expand upon the Telemental Health Program, implemented in 2010. More information is available at:

<https://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx>.

⁷ *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session). Available at Appendix A and: http://mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.

⁸ Telemedicine can help improve access to health care services, enhance the patient care experience, improve population health, and reduce costs. Telemedicine, as defined in Maryland law, means the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient. See Appendix B for a glossary of terms.

that is due December 1, 2014 will include recommendations aimed at increasing the use of telemedicine.

Over the last several months, the task force has explored options that could facilitate expanded use of telemedicine in innovative care delivery models. The Clinical Advisory Group and the Technology Solutions and Standards Advisory Group of the task force met nine times.⁹ The advisory groups are currently contemplating telemedicine use cases and the development of a provider registry aimed at identifying telemedicine providers and the technology they use. In 2014, the task force intends to finalize recommendations pertaining to the technology required to support a telemedicine registry; use cases to be implemented in a phased approach beginning in underserved and rural areas; and care delivery models leading to the adoption of telemedicine.

Limitations

This is an interim report on the work underway by the task force. The report is intended to provide the Governor and General Assembly with an update of activities, and it does not include recommendations for legislative action. Information included in the interim report is based on the nine meetings that occurred in 2013.

Task Force Background

The task force was originally convened in 2010 to identify opportunities for expanding telemedicine to improve health status and care delivery in the State.¹⁰ At the request of John Colmers, the former Secretary of the Maryland Department of Health and Mental Hygiene, the task force reconvened in 2011 to develop additional recommendations for advancing telemedicine, and three advisory groups were established: Clinical; Technology Solutions and Standards; and Finance and Business Model. The work of the 2011 task force was outlined in the December 2011 report, *Telemedicine Recommendations*, that was presented to the Maryland Quality and Cost Council.¹¹

Law enacted in 2012 required State-regulated payors to reimburse for services delivered through telemedicine.¹² In 2013, three laws intended to minimize the barriers to telemedicine adoption were passed, which include:¹³

- Senate Bill 798 (2013), *Hospitals – Credentialing and Privileging Process – Telemedicine*, enables hospitals to rely on certain credentialing and privileging decisions made by a distant site hospital or telemedicine entity;^{14,15}

⁹ See Appendix F for the task force 2013 meeting schedule.

¹⁰ The task force was convened in response to a report by the Maryland Department of Health and Mental Hygiene, *Improving Stroke Care through Telemedicine in Maryland* as well as the recommendations of the Maryland State Advisory Council on Heart Disease and Stroke as stated in their biannual report to the Governor in both 2007 and 2009.

¹¹ MHCC, *Telemedicine Recommendations*, December 2011. Available at: http://mhcc.dhmdh.maryland.gov/hit/telemedicine/Documents/sp.mhcc.maryland.gov/telemed/md_telemedicine_report.pdf.

¹² Md. Code Ann., Insurance § 15–139. See Appendix H.

¹³ For more information on these laws, as well as others governing the practice of telemedicine in Maryland, see Appendix A, H-L.

¹⁴ Md. Code Ann., Health - General § 19–319. See Appendix I.

- Senate Bill 496 (2013), *Maryland Medical Assistance Program – Telemedicine*, requires the Maryland Medical Assistance Program to provide reimbursement for certain services delivered through telemedicine under certain circumstances; and^{16,17}
- Senate Bill 776 (2013), *Telemedicine Task Force – Maryland Health Care Commission*, (SB 776) requires MHCC, in conjunction with the Maryland Health Quality and Cost Council, to reconvene the task force.¹⁸

Maryland Telemedicine Adoption

Telemedicine diffusion in Maryland has been slow and fragmented.¹⁹ In 2012, about 46 percent of Maryland acute care hospitals reported using telemedicine, and adoption among Maryland physicians has been lower at approximately 10 percent.^{20, 21} State-regulated payors have indicated that only about 78 claims have been process for services rendered through telemedicine.²²

Widespread use of telemedicine is expected to produce many benefits, including: increased access to health care services; greater efficiencies in care delivery; improved access to information; and reduced health care costs.²³ Recent studies suggest that in some cases, patient outcomes for certain services delivered through telemedicine in ambulatory settings appear to be comparable to services rendered in-person.^{24, 25, 26} Existing fee-for-service models of care delivery and payment encourage episodic care delivery. Absent a transition to value-based service delivery and payment programs outlined in the ACA, there is little incentive for the medical community to adopt telemedicine.

2013 Task Force

In accordance with SB 776, MHCC reconvened the task force to identify opportunities to further expand the use of telemedicine to improve health status and care delivery in the State. The task

¹⁵ See Appendix K for proposed Maryland regulations to allow hospitals to use the credentialing of the distant site hospital for physicians that provide telemedicine services.

¹⁶ Md. Code Ann., Health - General § 15-105.2. See Appendix J.

¹⁷ See Appendix L for Maryland Medicaid Telemedicine Regulations.

¹⁸ *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session). Available at Appendix A and: http://mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.

¹⁹ MHCC, *Telemedicine Information Brief*, July 2013. Available at:

http://mhcc.dhmh.maryland.gov/hit/telemedicine/Documents/telemedicine_updates_brief.pdf. See Appendix M.

²⁰ MHCC *Health Information Technology: An Assessment of Maryland Hospitals*. September 2013. Available at: http://mhcc.dhmh.maryland.gov/hit/Documents/2013_hospital_health_it_assessment.pdf

²¹ Maryland Board of Physicians licensure data, 2011-2012

²² Ibid n. 5.

²³ Journal of Telemedicine and Telecare, *Benefits and Drawbacks of Telemedicine*, 11(2) 2005.

²⁴ Journal of Pediatric Psychology, *Treating Rural Pediatric Obesity through Telemedicine: Outcomes from a Small Randomized Controlled Trial*, February 2013.

²⁵ Journal of the American Medical Association Neurology, *Randomized Controlled Clinical Trial of 'Virtual House Calls' for Parkinson Disease*, March 2013.

²⁶ American Journal of Psychiatry, *Practice-Based Versus Telemedicine-Based Collaborative Care for Depression in Rural Federally Qualified Health Centers: A Pragmatic Randomized Comparative Effectiveness Trial*, April 2013.

force is also required to assess factors related to telehealth²⁷ and to identify strategies for telehealth deployment in rural areas of the State. Over the next year, MHCC will work with its three advisory groups to further analyze the topics in SB 776 and formulate recommendations.²⁸

Clinical Advisory Group

The Clinical Advisory Group includes members from acute, ambulatory, post-acute, and home-based care, as well as representatives from State licensing boards and the medical society.²⁹ In the fall of 2013, the Clinical Advisory Group developed guiding principles (principles) to lead the work. Those principles center on the use of telemedicine to improve access to care and quality outcomes, boost health professional productivity, and support State and national initiatives to transform care delivery and reduce costs.³⁰

Scope of Work

- The role of telemedicine in advanced primary care delivery models; innovative service models for diverse care settings;
- Use cases for evaluation (e.g., stroke, dermatology, emergency services, etc.);
- Patient engagement, education, and outcomes;
- Health professional productivity, resources, and shortages; and
- Underserved population areas.

Barriers Identified to Telemedicine Diffusion

- Lack of widespread awareness about how to incorporate the effective use of telemedicine into existing practice workflows;
- Limited advocacy for telemedicine within the provider community; and
- Perception of high up-front costs for telemedicine technology.

Key Areas of Deliberation

- Increasing awareness among practices about how telemedicine may be integrated into innovative care delivery models;
- Developing a telemedicine program for medical and ancillary school curricula and continuing medical education credits;
- Increasing access to care in underserved rural and rural areas, wherever access to care is limited;
- Developing a draft list of clinical use cases for telemedicine that have the potential to improve health outcomes while containing costs;

²⁷ Telehealth includes non-clinical practices such as continuing medical education and nursing call centers (American Telemedicine Association). The use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance.

²⁸ See Appendix N for a table that identifies the topics for the task force outlined in SB 776, paired with the advisory group.

²⁹ See the Acknowledgements for a list of participants in the Clinical Advisory Group.

³⁰ See Appendix O for the guiding principles.

- Reviewing a national scan of other statewide telemedicine initiatives;³¹
- Establishing a lead entity to coordinate telemedicine efforts within the State; and
- Forming a sub-committee to further explore potential licensing and credentialing barriers to the adoption of telemedicine.

Policy Considerations

- Policy to guide the diffusion of telemedicine public health interventions and outcomes;
- Process measures to improve access to appropriate medical specialists; and
- Incorporation of evidence-based guidelines for services rendered through telemedicine.^{32, 33}

The Clinical Advisory Group expects to identify telemedicine use cases that offer evidence-based outcomes and cost savings opportunities in 2014. This group also plans to evaluate requirements for continuing education programs to include telemedicine curricula. As part of its work, the Clinical Advisory Group will consider potential licensing barriers to telemedicine adoption and develop recommendations to mitigate these barriers.

Technology Solutions and Standards Advisory Group

The Technology Solutions and Standards Advisory Group is comprised of representatives from academic medical centers, community hospitals, county health departments, third party payors, vendors, providers, Maryland Medicaid, the Department of Health and Mental Hygiene, and the State-Designated health information exchange (HIE). This group developed guiding principles to direct the discussions, which focus on how telemedicine technology can be a vital component of innovative care delivery models.^{34, 35}

Scope of Work

- Supportive uses of electronic health records (EHRs) and HIE;
- Emerging technology and standards for privacy and security; and
- Strategies for telehealth deployment in rural areas to increase access to health care.

Barriers Identified to Telemedicine Diffusion

- Availability of information about providers rendering telemedicine services;
- Integrating technology solutions with existing EHRs and HIEs; and
- Limited information about the availability of telemedicine service providers.

³¹ MHCC, *Telemedicine Statewide Networks - Environmental Scan*, October 2013. Available at: http://mhcc.dhmmh.maryland.gov/hit/telemedicine/Documents/telemedicine_%20networks_v3_revised_082813.pdf. See Appendix G.

³² See Appendix P for National Telemedicine Standards and Guidelines.

³³ See Appendix Q for the American Telemedicine Association *Core Telemedicine Operational Standards*.

³⁴ See the Acknowledgements for a list of participants in the Technology Solutions and Standards Advisory Group.

³⁵ See Appendix O for the guiding principles.

Key Areas of Deliberation

- The ability of ambulatory providers and hospitals to adopt technology solutions that best fit their needs;
- The development of a telemedicine provider registry (registry) that contains information on telemedicine providers, technology used, third party payor network, and availability to provide immediate consultative support. The registry is being conceptualized as follows:
 - A self-identified listing of telemedicine providers, including details about telemedicine capabilities;
 - Made available through the State-designated HIE query portal, which is a tool currently providing clinicians with access to clinical information from long-term care providers, laboratories, and radiology centers throughout Maryland; and
 - Implemented in a phased approach, allowing for enhancements over time:
 - *Phase 1 includes:* Provider information (name, practice location(s), specialty, insurance accepted, technology capabilities) and a resource center to provide educational information about telemedicine;
 - *Phase 2 includes:* Identifying providers currently available to deliver telemedicine services, and chat functionality for real-time communication;
 - *Phase 3 includes:* Consumer capabilities, integration with mobile devices, and features to attribute providers to practices and health systems in the registry.^{36, 37}

Policy Considerations

- Use of the registry in emergent situations;
- Validation of information in the registry;
- Determination of standards to enable interoperability wherever patient records are stored; and
- Achieving compliance with federal and State privacy and security laws.

The Technology Solutions and Standards Advisory Group plans to finalize the technical specifications in 2014. This group will also address policy challenges of a registry, such as enabling the inclusion of provider groups in addition to individual providers, and ensuring provider information is maintained and updated in a timely manner.

Finance and Business Model Advisory Group

The Finance and Business Model Advisory Group did not meet in 2013. It is comprised of representatives from academic medical centers, community hospitals, county health departments, payors, providers, Maryland Medicaid, and the Department of Health and Mental Hygiene. As the

³⁶ The State-Designated HIE is the Chesapeake Regional Information System for our Patients (CRISP). More information is available at: <http://crisphealth.org/>.

³⁷ Providers must sign a participation agreement with CRISP and all users complete a credentialing and training process before being authorized to query the portal.

work of the Clinical Advisory Group and the Technology Solutions and Standards Advisory Group progress, the Finance and Business Model Advisory Group will convene to develop recommendations pertaining to advancing telemedicine in innovative care delivery models.

Scope of Work

- Applications for cost-effective telehealth;
- Innovative payment models;
- Public and private grant funding; and
- Strategies for telehealth deployment to meet increased demand for health care services due to implementation of the ACA.

Barriers Identified to Telemedicine Diffusion

- Traditional fee-for-service payment models incentivize volume-based care; providers are often fully scheduled with in-person visits and may not see the value of incorporating telemedicine into their existing practice workflows;
- Medicaid reimbursement for telemedicine services are limited to pilot programs; and
- Requirements for federal grant funding for telemedicine in rural areas are restrictive in Maryland, as Maryland's federally defined rural regions are geographically small when compared to other states that have higher telemedicine adoption rates.^{38, 39, 40}

The Finance and Business Model Advisory Group will assess how telemedicine could be incorporated into the transformation of care delivery. This group will develop recommendations that stem from use cases and the technology under consideration by the Clinical Advisory Group and Technology Solutions and Standards Advisory Group.

Remarks

Telemedicine has the potential to improve access to health care services, enhance quality of care, and contain costs. In general, regulatory, reimbursement, and technology barriers limit the potential of telemedicine to meet these goals. Developing strategies to expand the diffusion and increase the use of telemedicine is a complex endeavor. Expanding adoption and increasing the use of telemedicine requires moving away from the way care is typically provided and embracing innovative approaches to care delivery. Over the next year, the task force will grapple with the difficult issues that must be addressed to ensure broad use of telemedicine in the future. The December 2014 report to the Governor and General Assembly will include recommendations supported by technology and a shift toward value-based delivery models.

³⁸ Ibid n. 8.

³⁹ See Appendix L for Maryland Medicaid Telemedicine Regulations.

⁴⁰ American Telemedicine Association, *State Telemedicine Legislation Tracking*, 2013. See Appendix D.

Acknowledgements

The MHCC thanks the members of the task force for their contributions. More than 100 stakeholders have participated to date in the task force. The enthusiasm of the participants is noteworthy. Many thanks to Kathy Montgomery, PhD, MHCC Commissioner, for her input on the report. The MHCC acknowledges the following individuals for their participation in the advisory groups.

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Appendix A: Senate Bill 776 (Chapter 319) (2013)

Begin quoted text

Chapter 319 (Senate Bill 776)

AN ACT concerning

~~Task Force on the Use of Telehealth to Improve Maryland Health Care~~

Telemedicine Task Force – Maryland Health Care Commission

FOR the purpose of ~~establishing the Task Force on the Use of Telehealth to Improve Maryland Health Care; providing for the membership, co-chairs, and staffing of the Task Force; providing for the duties of the Task Force; providing that a member of the Task Force may not receive certain compensation but is entitled to certain reimbursement; requiring the Task Force to provide certain reports to the Governor and the General Assembly on or before certain dates; providing for the termination of this Act; and generally relating to the Task Force on the Use of Telehealth to Improve Maryland Health Care~~ declaring the intent of the General Assembly that the Maryland Health Care Commission, in conjunction with the Maryland Health Quality and Cost Council, continue to study the use of telehealth throughout the State through the Telemedicine Task Force; requiring the Task Force to consist of certain advisory groups and undertake certain activities; and requiring the Commission, on or before certain dates, to submit certain reports of the Task Force to the Governor and certain legislative committees.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

~~(a) There is a Task Force on the Use of Telehealth to Improve Maryland Health Care.~~

~~(b) The Task Force consists of the following members:~~

~~(1) one member of the Senate of Maryland, appointed by the President of the Senate;~~

~~(2) one member of the House of Delegates, appointed by the Speaker of the House;~~

~~(3) the Secretary of Health and Mental Hygiene, or the Secretary's designee;~~

~~(4) the Director of the Department of Health and Mental Hygiene's Office of Rural Health, or the Director's designee;~~

~~(5) the Director of Program Development for the Maryland Critical Care Network Vice President of Telemedicine – University of Maryland Medical System, or the Director's Vice President's designee;~~

~~(6) the Executive Director of the Maryland Health Care Commission, or the Executive Director's designee;~~

~~(7) the Executive Director of the Rural Health Association, or the Executive Director's designee;~~

~~(8) the Executive Director of the Rural Maryland Council, or the Executive Director's designee;~~

~~(9) the Executive Director of the Maryland Institute for Emergency Medical Services Systems, or the Executive Director's designee; and~~

~~(10) the following members, appointed by the Governor:~~

~~(i) two representatives from the medical communities organizations that serve medically underserved populations in the State or are located in provider shortage underserved areas across the State that include both rural and urban areas;~~

~~(ii) two consumers or representatives of consumer advocate organizations;~~

~~(iii) one representative from the State health information exchange;~~

~~(iv) two representatives of the health insurance industry;~~

~~(v) two representatives from roundtables established in the State to study telehealth;~~

~~(vi) one representative from the State's Telemedicine Task Force of 2011;~~

~~(vii) one individual who provides home health care through telemedicine;~~

~~(viii) one individual who provides care through a patient-centered medical home;~~

~~(ix) one individual who provides acute care through telemedicine;~~

~~(x) one licensed psychiatrist;~~

~~(xi) one licensed provider of behavioral health services;~~

~~(xii) one representative of a hospital that is participating in telemedicine; and~~

~~(xiii) one representative of the Governor's Workforce Investment Board;~~

~~(xiv) two representatives of Federally Qualified Health Centers, including one from a center in a rural area and one from a center in an urban area;~~

~~(xv) one representative of the Maryland Chamber of Commerce; and~~

~~(xvi) one representative of the Arc of Maryland.~~

~~(c) The members appointed by the Presiding Officers of the General Assembly shall co-chair the Task Force.~~

~~(d) The Maryland Health Care Commission shall provide staff for the Task Force.~~

~~(e) A member of the Task Force:~~

~~(1) may not receive compensation as a member of the Task Force; but~~

~~(2) is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.~~

~~(f) The Task Force shall:~~

~~(1) identify opportunities to use telehealth to improve health status and health care delivery in the State, including an analysis of:~~

- ~~(i) underserved populations and areas;~~
- ~~(ii) applications for cost-effective telehealth;~~
- ~~(iii) innovative service models for diverse care settings to include chronic and acute care; and~~
- ~~(iv) innovative payment models; and~~
- ~~(v) the types of telehealth services that are resulting, or would result, in cost-effective care and improved outcomes for patients in the Medicaid program;~~

~~(2) assess factors related to telehealth, including an analysis of:~~

- ~~(i) supportive uses of electronic health records and the health information exchange;~~
- ~~(ii) multimedia uses of products and services for patient engagement, education, and outcomes;~~
- ~~(iii) health professional productivity, resources, and shortages;~~
- ~~(iv) emerging technology and standards for security; and~~
- ~~(v) public and private grant funding; and~~
- ~~(vi) whether the term “telemedicine”, as defined in § 15-139 of the Insurance Article, should be amended to include a reference to a service, known as an “electronic visit” or “e-visit”, that:~~

~~1. includes an online medical evaluation and management service;~~

~~2. is completed using a HIPAA-compliant online connection and a secured Web site or secured electronic mail address for each patient encounter; and~~

~~3. creates a permanent record of each visit;~~

~~(3) collaborate with:~~

- ~~(i) roundtables established to study telehealth uses in the State;~~
- ~~(ii) the Rural Maryland Council; and~~
- ~~(iii) any other organization that the co-chairs of the Task Force consider appropriate;~~

~~(4) review and consider any studies, reports, or other work completed by the roundtables;~~

~~(5) study any other topic that the Task Force finds necessary to make recommendations regarding the use of telehealth in the State; and~~

~~(6) make recommendations regarding the use of telehealth in the State, including recommendations for:~~

- ~~(i) improving health care affordability, accessibility, and quality;~~
- ~~(ii) developing a model for statewide telehealth infrastructure, service, and access;~~
- ~~(iii) utilizing public and private grant funding;~~
- ~~(iv) providing workforce training; and~~
- ~~(v) improving public health.~~

~~(g) (1) On or before May 1, 2014 December 1, 2013, the Task Force shall provide an interim report on the status of the activities of the Task Force to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.~~

~~(2) On or before December 1, 2014 2015, the Task Force shall provide a final report on its findings and recommendations to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.~~

(a) It is the intent of the General Assembly that the Maryland Health Care Commission, in conjunction with the Maryland Health Quality and Cost Council, continue to study the use of telehealth throughout the State through the Telemedicine Task Force.

(b) The Task Force shall:

(1) consist of three existing advisory groups:

- (i) the clinical advisory group;*
- (ii) the technology solutions and standards advisory group; and*
- (iii) the financial and business model advisory group;*

(2) identify opportunities to use telehealth to improve health status and care delivery in the State that includes an analysis of:

- (i) underserved population areas;*
- (ii) applications for cost-effective telehealth;*
- (iii) innovative service models for diverse care settings to include chronic and acute care; and*

(iv) innovative payment models;

(3) assess factors related to telehealth that includes an analysis of:

- (i) supportive uses of electronic health records and health information exchange;*
- (ii) multimedia uses of products and services for patient engagement, education, and outcomes;*
- (iii) health professional productivity, resources, and shortages;*
- (iv) emerging technology and standards for security; and*
- (v) public and private grant funding;*

(4) identify strategies for telehealth deployment in rural areas of the State to increase access to health care and meet any increased demand for health care due to the implementation of the Patient Protection and Affordable Care Act; and

(5) study any other topic the Maryland Health Care Commission finds necessary to make recommendations regarding the use of telehealth in the State.

(c) The Maryland Health Care Commission shall submit to the Governor and, in accordance with § 2-1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee:

(1) on or before January 1, 2014, an interim report of the Task Force findings and recommendations; and

(2) on or before December 1, 2014, a final report of the Task Force findings and recommendations.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect ~~October 1, 2013~~ July 1, 2013. It shall remain effective for a period of ~~1 year and 8 months~~ 2 years and, at the end of ~~May 31, June 30, 2015-2016~~ 2015, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

Approved by the Governor, May 2, 2013.

End quoted text

Appendix B: Glossary

Telemedicine: Telemedicine, as defined in Maryland law, means the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient.

Telehealth: Often used as a synonym for telemedicine, and also includes non-clinical practices such as continuing medical education and nursing call centers (American Telemedicine Association). The use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance.

Telecare: Telecare is a term given to offering remote care of elderly and vulnerable people, providing the care and reassurance needed to allow them to remain living in their own homes. Continuous, automatic and remote monitoring to manage the risks associated with independent living (American Telemedicine Association).

Telelearning: A telelearning system facilitates the provision of education and training services to health care professionals or patients. It is typically a room-based videoconferencing system with some additional attachments, such as a scanner, VCR, a document camera or a computer (American Telemedicine Association).

Telementoring: The use of audio, video, and other telecommunications and electronic information processing technologies to provide individual guidance or direction. An example of this help may involve a consultant aiding a distant clinician in a new medical procedure (American Telemedicine Association).

Telemonitoring: The process of using audio, video, and other telecommunications and electronic information processing technologies to monitor the health status of a patient from a distance (American Telemedicine Association).

Telepresence: The method of using robotic and other instruments that permit a clinician to perform a procedure at a remote location by manipulating devices and receiving feedback or sensory information that contributes to a sense of being present at the remote site and allows a satisfactory degree of technical achievement. For example, this term could be applied to a surgeon using lasers or dental hand pieces and receiving pressure similar to that created by touching a patient, so that it seems as though the patient is actually present, permitting a satisfactory degree of dexterity (American Telemedicine Association).

Appendix C: Reimbursable Medicare Telemedicine Services

*Begin quoted text*⁴¹

MEDICARE PAYMENT OF TELEMEDICINE AND TELEHEALTH SERVICES

January 2013

Medicare reimbursement for telemedicine or telehealth services is divided into three areas:

1. Remote patient face-to-face services seen via live video conferencing
2. Non face-to-face services that can be conducted either through live video conferencing or via store and forward telecommunication services
3. Home telehealth services

In addition, national and local coverage determinations may alter or expand the services that are eligible for reimbursement.

1. Remote Patient Face-To-Face, Interactive Services

The Centers for Medicare and Medicaid Services (CMS) defines telehealth services to include those services that require a face-to-face meeting with the patient. Reimbursement for these services was initiated through Congressional legislation. Such reimbursement is limited to the type of services provided, geographic location, type of institution delivering the services and type of health provider.

Location of Facility

The service must be provided to an eligible Medicare beneficiary in an eligible facility (originating site) located outside of a Metropolitan Statistical Area (State-specific maps of Metropolitan Statistical Areas are at http://www.census.gov/geo/www/maps/stcbsa_pg/stBased_200411_nov.htm). However, there is no limitation on the location of the health professional delivering the medical service (referring site).

Eligible Medical Services

Services that are eligible for reimbursement include consultation, office visits, individual psychotherapy and pharmacologic management delivered via a telecommunications system. The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy and pharmacologic management.

The 2013 list of Medicare telehealth covered services is (by CPT or HCPCS codes)—

- 90791 and 90792: Psychiatric diagnostic interview examination
- 90832 – 90834 and 90836 – 90838: Individual psychotherapy

⁴¹ American Telemedicine Association, *Telemedicine and Telehealth Services*, January 2013. Available at: <http://www.americantelemed.org/docs/default-source/policy/medicare-payment-of-telemedicine-and-telehealth-services.pdf>.

- 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961: End-Stage Renal Disease-related services included in the monthly capitation payment
- 96116: Neurobehavioral status examination
- 96150 – 96154: Individual and group health and behavior assessment and intervention
- 97802 – 97804 and G0270: Individual and group medical nutrition therapy
- 99201 – 99215: Office or other outpatient visits
- 99231 – 99233: Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days
- 99307 – 99310: Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days
- 99406 and 99407 and G0436 and G0437: Smoking cessation services
- G0108 and G0109: Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training
- G0396 and G0397: Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services
- G0406 – G0408: Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs
- G0420 and G0421: Individual and group kidney disease education services
- G0425 – G0427: Telehealth consultations, emergency department or initial inpatient
- G0442: Annual alcohol misuse screening, 15 minutes
- G0443: Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
- G0444: Annual depression screening, 15 minutes
- G0445: High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes
- G0446: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes
- G0447: Face-to-face behavioral counseling for obesity, 15 minutes
- G0459: Inpatient pharmacologic management

Eligible Providers

Only the following health professionals may claim reimbursement for remote telehealth services:⁴²

- Physician;
- Nurse practitioner;

⁴² Ibid, Part 270.4 – Payment – Physician/Practitioner at a Distant Site

- Physician assistant;
- Nurse midwife;
- Clinical nurse specialist;
- Clinical psychologist,*
- Clinical social worker;* and
- Registered dietitian or nutrition professional.

* Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.

Eligible Facilities

Only the following facilities are eligible to be an originating site under the rules of the program:⁴³

- The office of a physician or practitioner
- A hospital, including a critical access hospital
- A rural health clinic
- A federally qualified health center
- A skilled nursing facility
- A hospital-based dialysis center
- A community mental health center

Reimbursement Amounts

Reimbursement to the health professional delivering the medical service is the same as the current fee schedule amount for the service provided. In addition, the non-metropolitan facility with the patient is eligible to receive a facility fee. Claims for reimbursement should be submitted with the appropriate CPT code for the professional service provided and the telehealth modifier “GT” – “via interactive audio and video telecommunications system.” For billing policies and recent changes regarding telehealth services see a recent CMS document (Pub 100-04 Medicare Claims, Transmittal 106) located at <http://www.cms.hhs.gov/Transmittals/Downloads/R1026CP.pdf>. For the most recent payment policies regarding the telehealth originating site fee see the CMS document “MLN Matters Number: MM5443” located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5443.pdf>.

Claims submission

Claims for professional consultations, office visits, individual psychotherapy, and pharmacologic management provided via a telecommunications system are submitted to the carrier that processes claims for the performing physician/practitioner's service area.

⁴³ Ibid, Part 270.01 – Eligibility Criteria

Physicians/practitioners submit the appropriate CPT procedure code for covered professional telehealth services along with the "GT" modifier ("via interactive audio and video telecommunications system"). By coding and billing the "GT" modifier with a covered telehealth procedure code, the distant site physician/practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished.

To claim the facility payment, physicians/practitioners will bill HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." The type of service for the telehealth originating site facility fee is "9, other items and services." For carrier processed claims, the "office" place of service (code 11) is the only payable setting for code Q3014. There is no participation payment differential for code Q3014 and it is not priced off of the Medicare Physician Fee Schedule Database file. Deductible and coinsurance rules apply to Q3014. By submitting HCPCS code "Q3014", the biller certifies that the originating site is located in either a rural HPSA or a non-MSA county.

Physicians and practitioners at the distant site bill their local Medicare carrier for covered telehealth services, for example, "99245 GT". Physicians' and practitioners' offices serving as a telehealth originating site bill their local Medicare carrier for the originating site facility fee.⁴⁴

Store and Forward Exception

Federal demonstration programs providing telemedical services in Alaska and Hawaii have also been granted the authority to bill Medicare for normal face-to-face services that use store and forward telemedicine.

2. Remote Non Face-to-Face Services

Services delivered using telecommunications technology but not requiring the patient to be present during their implementation are covered the same as services delivered when on-site at the medical facility.

"A service may be considered to be a physician's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of x-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc.

For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram reading that has been transmitted via telephone (i.e., electronically rather than by means of a verbal description) is a covered service."⁴⁵

⁴⁴ CMS Carriers Manual Part 3 Chapter IV Claims Review and Adjudication Procedures

http://www.cms.hhs.gov/manuals/14_car/3b4120.asp

⁴⁵ Medicare benefit policy manual, Part 15 – Covered Medical and Other Health Services, 30-Physician Services pp 10-11. (http://www.cms.hhs.gov/manuals/102_policy/bp102c15.pdf)

These remote services are NOT considered “telehealth” or “telemedicine” by CMS. Rather, they are considered the same as services delivered on-site and are to be coded and will be paid in the same way. There are no geographic or facility limitations on these services.

The largest single specialty providing remote services under this policy is radiology. However, the use of telecommunications in delivering pathology, cardiology, physician team conferences and other services are also covered. Special CPT Codes are used for the remote assessment of pacemakers as well as the collection and assessment of data from cardiac event recorders.

3. Home Telehealth

Section 1895(e) of the Act states that telehealth services are outside the scope of the Medicare home health benefit and home health PPS. This provision does not provide coverage or payment for Medicare home health services provided via a telecommunications system. The law does not permit the substitution or use of a telecommunications system to provide any covered home health services paid under the home health PPS, or any covered home health service paid outside of the home health PPS. As stated in 42 CFR 409.48(c), a visit is an episode of personal contact with the beneficiary by staff of the home health agency (HHA), or others under arrangements with the HHA for the purposes of providing a covered service.

However, this provision clarifies that there is nothing to preclude a home health agency from adopting telemedicine or other technologies that they believe promote efficiencies, but that those technologies will not be specifically recognized or reimbursed by Medicare under the home health benefit. This provision does not waive the current statutory requirement for a physician certification of a home health plan of care under current §§1814(a)(2)(C) or 1835(a)(2)(A) of the Act.⁴⁶

Within its home health agency manual, CMS states that “An HHA may adopt telehealth technologies that it believes promote efficiencies or improve quality of care. Telehomecare encounters do not meet the definition of a visit set forth in regulations at 42 CFR 409.48(c) and the telehealth services may not be counted as Medicare covered home health visits or used as qualifying services for home health eligibility. An HHA may not substitute telehealth services for Medicare-covered services ordered by a physician. However, if an HHA has telehealth services available to its clients, a doctor may take their availability into account when he or she prepares a plan of treatment (i.e., may write requirements for telehealth services into the POT). Medicare eligibility and payment would be determined based on the patient’s characteristics and the need for and receipt of the Medicare covered services ordered by the physician. If a physician intends that telehealth services be furnished while a patient is under a home health plan of care, the services should be recorded in the plan of care along with the Medicare covered home health services to be furnished.”⁴⁷

⁴⁶ Medicare Benefit Policy Manual Chapter 7 Home Health Services, Part 110

⁴⁷ Publication 11 - Home Health Agency Manual - Chapter II - Coverage of Services, Part 201.13
<http://www.cms.hhs.gov/manuals/cmstoc.asp>.

National and Local Coverage Decisions

Certain national coverage determinations by CMS has further expanded and explained coverage. For example, Part 20.8.1.1 of the National Coverage Determinations manual covers transtelephonic monitoring of cardiac pacemakers and Part 20.15 covers electrocardiographic services (see below).

"50-39 TELEPHONE TRANSMISSION OF ELECTROENCEPHALOGRAMS

Telephone transmission of electroencephalograms (EEGs) is covered as a physician's service or as incident to a physician's service when reasonable and necessary for the individual patient, under appropriate circumstances. The service is safe, and may save time and cost in sending EEGs from remote areas without special competence in neurology, neurosurgery, and electroencephalography, by avoiding the need to transport patients to large medical centers for standard EEG testing.

Telephone transmission of EEGs has been most helpful in the following clinical situations:

- *Altered consciousness, such as stuporous, semicomatose, or comatose states;*
- *Atypical seizure variants in patients experiencing bizarre, distressing symptoms as seen with "spike and wave stupor" or other forms of seizure disorders;*
- *Diagnosis of a suspected intracranial tumor;*
- *Head injury, where a subdural hematoma may be identified;*
- *Headaches during the acute phase where, for instance, in migraine syndrome, abnormal responses may be seen.*

Telephonically transmitted EEGs should not be used for determining electrical inactivity (i.e., brain death), because of unavoidable signal interference.

In addition, local intermediaries are allowed to make their own local determinations regarding, which may further expand coverage. For example, the Arkansas Blue Cross Blue Shield - Rhode Island intermediary has a ruling titled: Transtelephonic Spirometry where patient initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation are covered.

Cardiac monitoring

Medicare also covers two types of cardiac monitoring:

- Transtelephonic monitoring of cardiac pacemakers (CPT code 93293) is for identifying early signs of possible pacemaker failure, thus reducing the number of sudden pacemaker failures requiring emergency replacement.
- Ambulatory electrocardiography (AECG) refers to services rendered in an outpatient setting over a specified period of time, generally while a patient is engaged in daily activities. AECG devices are intended to provide the physician with documented episodes of arrhythmia, which may not be detected using a standard EKG. AECG is most typically used to evaluate symptoms that may correlate with intermittent cardiac arrhythmias and/or myocardial ischemia. The AECG are both

patient/event-activated and continuous recorders and use CPT codes 93271 and 93012. These services are performed by independent diagnostic testing facilities (IDTFs).

End quoted text

Appendix D: 2013 Telemedicine Reimbursement Legislation Tracking

The American Telemedicine Association maintains a summary of activity related to telemedicine among state legislatures in the U.S. For more information, please visit www.americantelemed.org.

Begin quoted text

2013 State Telemedicine Legislation Tracking (as of 10/29/2013) *				
State	Legislated Mandate for Private Coverage	Legislated Medicaid Coverage (primarily interactive video)	Other Bills Affecting Telemedicine Access or Coverage	Notes
Alabama				
Alaska			Proposed	SB 80 - out-of-state physician licensure (STATUS: Died in Session)
Arizona	✓			SB 1353 (STATUS: SIGNED INTO LAW 4/8/13)
Arkansas				
California	✓	✓	Proposed	AB 809 - changes to informed consent for telemed; AB 318 - Medicaid coverage of dental care via store-and-forward; AB 1174 - Medicaid coverage of dental care via store-and-forward; AB 1231 - Telehealth and services for individuals with developmental disabilities including autism (STATUS: Vetoed by Governor)
Colorado	✓	✓		SB 180 - recognizes telehealth as an allowable method of delivering consultative services for the practice of occupational therapy (STATUS: SIGNED INTO LAW 6/5/13)
Connecticut	Proposed			SB No. 40 and SB 858 (STATUS: DIED IN SESSION)
Delaware				
DC	✓	✓		B20-0050 (STATUS: SIGNED 7/23/13 and ENACTED 10/17/13); B20-248 and B20-249
Florida	Proposed	Proposed		SB 70 and HB 167 (new bills for 2014 session); HB 499 and SB 898 (STATUS: DIED IN COMMITTEE)
Georgia	✓			
Hawaii	✓			
Idaho				

2013 State Telemedicine Legislation Tracking (as of 10/29/2013) *

State	Legislated Mandate for Private Coverage	Legislated Medicaid Coverage (primarily interactive video)	Other Bills Affecting Telemedicine Access or Coverage	Notes
Illinois	Proposed			SB 1422 and SB 2366; HB 2996 - allows delivery of occupational therapy via telehealth (STATUS: SIGNED INTO LAW 8/9/13)
Indiana		✓		SB 554 - For Rural Centers, FQHCs, Home health, CAHSs, and Community mental health centers (STATUS: SIGNED INTO LAW 5/13/13)
Iowa				
Kansas			Proposed	SB 175, HB 2317, and HB 2395 - Autism treatment coverage (STATUS: DIED IN SESSION)
Kentucky	✓	✓		
Louisiana	✓			
Maine	✓			
Maryland	✓	✓		SB 496 (STATUS: SIGNED INTO LAW 5/2/13)
Massachusetts	Proposed	Proposed	✓	H. 1951 - comprehensive mandate for all health plans including Medicaid; S. 530 and H. 2114 - mandates coverage for telemedicine under private, medicaid, and state employee plans (STATUS: Hearing scheduled for 10/29); S. 467 - mandates coverage for private and state employee plans only; H. 948 - mandates coverage for telepsych services; H. 3538 - Medicaid coverage of home remote patient monitoring (STATUS: Senate and House override Governor's veto 7/24 and 7/30)
Michigan	✓		✓	HB 4714 - Allow telemedicine under ACA Medicaid expansion (STATUS: SIGNED INTO LAW 9/16/13)
Minnesota		✓		
Mississippi	✓	✓		SB 2209 (STATUS: SIGNED INTO LAW 4/1/13)
Missouri	✓			HB 986--formerly SB 262 (STATUS: SIGNED INTO LAW 7/8/13); HB 936 - Allows APRNs to practice telehealth in rural areas

2013 State Telemedicine Legislation Tracking (as of 10/29/2013) *				
State	Legislated Mandate for Private Coverage	Legislated Medicaid Coverage (primarily interactive video)	Other Bills Affecting Telemedicine Access or Coverage	Notes
Montana	✓			SB 270 (STATUS: SIGNED INTO LAW 4/5/13)
Nebraska		✓	✓	LB 505 and 605 - Telebehavioral (STATUS: CARRYOVER TO 2014 SESSION); and LB 556 - child behavioral health (STATUS: SIGNED INTO LAW 6/4/13)
Nevada			✓	SB 369 - Telemedicine practice for osteopathic physicians; SB 327 - Telepharmacy and Telemedicine practice for physicians (STATUS: SIGNED INTO LAW 6/2/13)
New Hampshire	✓			
New Jersey			Proposed	A4127 and SB 3024 - Medicaid coverage for telepsychiatry; S2916 - Medicaid coverage of telemental health in FQHCs
New Mexico	✓			SB 69 (STATUS: SIGNED INTO LAW 4/2/13)
New York	Proposed	Proposed	Proposed	S04337 and A06972 - Requires telemedicine coverage under private insurance and Medicaid (STATUS: CARRYOVER TO 2014 SESSION); S04023 - Medicaid reimbursement for capital costs related to telemedicine (STATUS: CARRYOVER TO 2014 SESSION)
North Carolina			✓	SB 98 (STATUS: SIGNED INTO LAW 5/8/13) and HB 105 - Medicaid coverage for neonatal screening
North Dakota				
Ohio	Proposed	Proposed	Proposed	HB 123 and SB 166 - Medicaid expansion (STATUS: Passed the House and Sent to Senate); SB 118
Oklahoma	✓		✓	HB 2089 - repeal informed consent for telemed; HB 1235 - Allows Osteopathic Medical Board to issue telemedicine license (STATUS: SIGNED INTO LAW 5/10/13)
Oregon	✓		Proposed	HB 3378 - State employee health plan coverage of telemedicine (STATUS: DIED IN SESSION)

2013 State Telemedicine Legislation Tracking (as of 10/29/2013) *				
State	Legislated Mandate for Private Coverage	Legislated Medicaid Coverage (primarily interactive video)	Other Bills Affecting Telemedicine Access or Coverage	Notes
Pennsylvania	Proposed			HB 491; SB 1083 and HB 1655 - Establish patient-centered medical home model with consideration for telemedicine
Rhode Island			Proposed	S 753 and H 5725 - physician licensure (STATUS: Died in Session)
South Carolina	Proposed			SB 290 and HB 3779 (STATUS: CARRYOVER TO 2014 Session)
South Dakota				
Tennessee	Proposed			SB 484 and HB 923 (STATUS: CARRYOVER TO 2014 Session)
Texas	✓	✓	Proposed	HB 1470 - Medical board standards; HB 1806 - Telemedicine coverage; SB 830 - Telemedicine in trauma facilities (STATUS: Died in Session)
Utah				
Vermont	✓	✓	✓	H 272 and S 88 - related to telemedicine services outside of healthcare facility (STATUS: SIGNED INTO LAW. Law will focus on a pilot program to study effects of telemedicine when delivered outside of healthcare facility.)
Virginia	✓			
Washington	Proposed			HB 1448 (STATUS: CARRYOVER TO 2014 Session)
West Virginia			✓	HB 2577 - revises laws related to the practice of pharmacy (STATUS: SIGNED INTO LAW 5/3/13)
Wisconsin				AB 458 - amends practice guidelines for telemental health providers
Wyoming				
* Does Not Include State Administrative or Regulatory Orders				
✓ Previously Enacted				

End quoted text

Appendix E: State Telemedicine Licensure Overview

The Federation of State Medical Boards summarizes State licensure requirements, legislation, regulation, and policy guidelines related to telemedicine. For more information, please visit http://www.fsmb.org/pdf/grpol_telemedicine_licensure.pdf.

Begin quoted text

Document Summary:⁴⁸

- Ten (10) state boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine.
- Fifty-seven (57) state boards plus the DC Board of Medicine require that physicians engaging in telemedicine are licensed in the state in which the patient is located.
- Minnesota allows physicians to practice telemedicine if they are registered to practice telemedicine or are registered to practice across state lines.
- Fifteen (15) states currently require private insurance companies to cover telemedicine services to the same extent as face-to-face consultations.
- Massachusetts permits coverage for services provided through telemedicine as long as the deductible, copayment or coinsurance doesn't exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
Alabama	Board can issue a special purpose license to practice across state lines upon application	No person shall engage in the practice of medicine or osteopathy across state lines in this state, hold himself or herself out as qualified to do the same, or use any title, word or abbreviation to indicate to or induce others to believe that he or she is licensed to practice medicine or osteopathy across state lines in this state unless he or she has been issued a special purpose license to practice medicine or osteopathy. ALA. CODE § 34-24-502. The commission shall only issue a special purpose license to practice medicine or osteopathy across state lines to an applicant whose principal practice location and license to practice is located in a state or territory of the United States whose laws permit or allow for the issuance of a special purpose license to practice medicine or osteopathy across state lines or similar license to a physician whose principal practice location and license is located in this state. It is the stated intent of this article that physicians and osteopaths who hold a full and current license in the	

⁴⁸ M = Medical Board licensure requirements; O = Osteopathic Board licensure requirements

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
		State of Alabama be afforded the opportunity to obtain, on a reciprocal basis, a license to practice medicine or osteopathy across state lines in any state or territory of the United States as a pre-condition to the issuance of a special purpose license as authorized by this article to a physician or osteopath licensed in such state or territory. The State Board of Medical Examiners shall determine which states or territories have reciprocal licensure requirements meeting the qualifications. ALA. CODE § 34-24-507.	
Alaska	Must obtain an Alaska license.	“Telemedicine” means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of medical data, audio, visual or data communications that are performed over two or more locations between providers who are physically separated from the recipient or from each other.” 7 ALASKA ADMIN. CODE § 110.639(4).	
Arizona - M	Must obtain an Arizona license.	“Telemedicine” means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video, or data communications that occur in the physical presence of the patient, including audio or video communications sent to a health care provider for diagnostic or treatment consultation. ARS § 36-3601.	
Arizona - O	Must obtain an Arizona license.	A physician who is physically located outside this state but who through the use of any medium, including an electronic medium, performs an act that is part of a patient care service initiated in this state, including the performance or interpretation of an X-ray examination or the preparation or interpretation of pathological material that would affect the diagnosis or treatment of the patient, is engaged in the practice of medicine in this state for the purposes of this chapter and is subject to appropriate regulation by the Arkansas State Medical Board. ARK. CODE R. § 17-95-206.	
Arkansas			

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
California - M	Must obtain a California license. Requires reimbursement for telemedicine services.	<p>“Telehealth” means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site.”CAL. BUS. AND PROF. CODE § 2290.5(a)(6)</p> <p>(c) No health care service plan shall require that in-person contact occur between a health care provider and a patient before payment is made for covered services appropriate provided through telehealth. CAL. HEALTH AND SAFETY CODE § 1374.13(c)</p> <p>There are no legal prohibitions to using technology in the practice of medicine as long as the practice is done by a California licensed physician. Telemedicine is not a telephone conversation, e-mail/instant messaging conversation, or fax; it typically involves the application of videoconferencing or store and forward technology to provide or support health care delivery. See http://www.mbc.ca.gov/licensee/telemedicine.html.</p> <p>(b) The board may, at its discretion, develop a proposed registration program to permit a physician and surgeon, or a doctor of podiatric medicine, located outside this state to register with the board to practice medicine or podiatric medicine in this state across state lines. CAL. BUS. & PROF. CODE § 2052.5(b). See note section.</p>	<p>California has no telemedicine registration program. In 1996, the Board sought legislation to obtain the regulatory authority to develop a program for physicians in other states to become registered in California, without requiring full licensure. The legislation was unsuccessful in obtaining regulatory authority, and, instead, added Section 2052.5 of the Business & Professions Code. This code has been the source of some confusion, as it outlines the original proposal for the registration program, but requires the Board to seek legislation to place a future program in statute. Those unfamiliar with the law's history assume that the Board</p>

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
			has a program or the authority to implement one—the Board has neither.
California - O	Must obtain a California license.	See above CAL. BUS. & PROF. CODE.	
Colorado	Must obtain a Colorado license.	No health benefit plan that is issued, amended or renewed for a person residing in a county with one hundred fifty thousand or fewer residents may require face-to-face contact between a provider and a covered person for services appropriately provided through telemedicine. COLO. CODE REGS. § 10-16-123(2). The delivery of telemedicine. Nothing in this paragraph (g) authorizes physicians to deliver services outside their scope of practice or limits the delivery of health services by other licensed professionals, within the professional's scope of practice, using advanced technology, including, but not limited to, interactive audio, interactive video, or interactive data communication. CRSA § 12-36-106(1)(g).	Limited licensure permitted for physicians licensed to practice medicine in another state if they are associated with Shriner's Hospital.
Connecticut	Must obtain a Connecticut license.		2012 CT HB 5483 seeks to have telemedicine services added to the state Medicaid plan so that providers are reimbursed for providing telemedicine services. Signed by the Governor 6/8/2012.
Delaware	Must obtain a		

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
	Delaware license		
DC	Must obtain a DC license.		
Florida - M	Must obtain a Florida license.	Prescribing medication based solely on an electronic medical questionnaire constitutes unprofessional conduct and is grounds for disciplinary action. Additionally, osteopathic physicians may not provide treatment recommendations unless a document patient evaluation has occurred, sufficient dialogue between the physician and patient regarding treatment options and the risks and benefits of treatment have occurred, and medical records are properly maintained. The aforementioned rule does not apply to an emergency situation and should not be construed to prohibit patient care in consultation with another physician who has an ongoing relationship with the patient, has agreed to supervise the patient's treatment. FLA. ADMIN. CODE ANN. R. 64B8-9.014.	Licensure exemption for certain out-of-state professionals employed by a sports entity visiting the state for a specific sporting event. FLA. STAT. § 456.023(1).
Florida - O	Must obtain a Florida license.	Prescribing medication based solely on an electronic medical questionnaire constitutes unprofessional conduct and is grounds for disciplinary action. Additionally, osteopathic physicians may not provide treatment recommendations unless a document patient evaluation has occurred, sufficient dialogue between the physician and patient regarding treatment options and the risks and benefits of treatment have occurred, and medical records are properly maintained. The aforementioned rule does not apply to an emergency situation and should not be construed to prohibit patient care in consultation with another physician who has an ongoing relationship with the patient, has agreed to supervise the patient's treatment. FLA. ADMIN. CODE ANN. R. 64B15-14.008.	
Georgia	Must obtain a Georgia license. Requires reimbursement for telemedicine services.	"Telemedicine" means the practice, by a duly licensed physician or other health care provider acting within the scope of such provider's practice, of health care delivery, diagnosis, consultation, treatment or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient. GA. CODE. ANN. § 33-24-56.4(b)(3). Every health benefit policy that is issued, amended	

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		<p>or renewed shall include payment for services that are covered under the policy and appropriately provided through telemedicine. GA. CODE ANN. § 33-24-56.4(c).</p> <p>A person who is physically located in another state or foreign country and who, through the use of any means, including electronic, radiographic, or other means of telecommunication, through which medical information or data are transmitted, performs an act that is part of a patient care service located in this state, including but not limited to the initiation of imaging procedures or the preparation of pathological material for examination, and that would affect the diagnosis or treatment of the patient is engaged in the practice of medicine in this state. Any person who performs such acts through such means shall be required to have a license to practice medicine in this state and shall be subject to regulation by the board. Any such out-of-state or foreign practitioner shall not have ultimate authority over the care or primary diagnosis of a patient who is located in this state. Ga. Code Ann. § 43-34-31.</p> <p>Any person holding him- or herself out to the public as being engaged in the practice of medicine must possess a valid license to practice medicine in the State of Georgia unless in the case of an emergency or the physician is engaged in consultation on special cases approved by the medical board of regularly licensed physicians from other states or territories. GA CODE ANN. § 43-34-22.</p>	
Hawaii	Must obtain a Hawaii license. Requires reimbursement for telemedicine services.	<p>Exceptions to the licensure requirement apply to a practitioner of medicine and surgery from another state when in actual consultation, including in-person, mail, electronic, telephonic, fiber-optic or other telemedicine consultation with a licensed physician or osteopathic physician of Hawaii, if the physician from out-of-state is licensed to practice in the state in which the physician resides at the time of consultation and he/she does not open an office, appoint a place to meet patients in Hawaii, or receive calls within the state; the physician licensed in Hawaii retains control and responsibility for the provision of care for the in-state patient; etc. HAW. REV. STAT. § 453-2(b)(3).</p> <p>“Telemedicine” means the use of telecommunications services, including real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure</p>	A radiologist licensed in another state may use telemedicine in Hawaii to provide radiology services to a patient located in the state in which the radiologist is licensed. HAW. REV. STAT. § 453-2(b)(6).

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
		<p>asynchronous information exchange, to transmit patient medical information, such as diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, and deliver health care services and information to parties separated by distance. HAW. REV. STAT. § 453-2(b)(6).</p> <p>No mutual benefit society plan that is issued, amended or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices. Haw. Rev. Stat. § 432:1-601.5(b).</p>	
Idaho	Must obtain an Idaho license.		
Illinois	Must obtain an Illinois license.	<p>“Telemedicine” means the performance of any of the activities listed in Section 49, including but not limited to rendering written or oral opinions concerning diagnosis or treatment of a patient in Illinois by a person located outside the state as a result of transmission of individual patient data by telephonic, electronic, or other means of communication from within this State. 225 ILL. COMP. STAT. ANN. 60/49.5(c).</p>	
Indiana	Must obtain an Indiana license		
Iowa	Must obtain an Iowa license.	<p>It is the Iowa Board of Medicine’s policy to require any physician who participates in the diagnosis and treatment of a patient situated in Iowa to obtain licensure. However, there is a provision in the Board’s authorizing statute which permits physicians not licensed in Iowa to provide medical consultation and services which are “incidental” to the care of patients. Medical reports used for “primary diagnostic purposes” are generally not considered incidental and thus are seldom exempted under this provision...The board cautions Iowa physicians to adhere to the rules governing the practice of medicine in the state, particularly those relating to the proper delegation of care. Out-of-state physicians should also be made aware that state law mandates that the unauthorized practice of medicine in Iowa is a felony. Although the Board can not sanction a physician not licensed in this state for an inaccurate reading of an x-ray or a missed diagnosis, it can and</p>	

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		will take the appropriate action against the Iowa physician who relied on the diagnosis and who is ultimately responsible and thus accountable for the patient's care. See policy statement at: http://medicalboard.iowa.gov/policies/telemedicine.html .	
Kansas	Must obtain a Kansas license.		
Kentucky	Must obtain a Kentucky license. Requires reimbursement for telemedicine services.	Physicians living outside Kentucky but actively practicing medicine upon patients within Kentucky should be required to meet the same statutory qualifications and should be held to the same standards of acceptable and prevailing medical practice within the Commonwealth as are resident physicians practicing within the state. See policy statement at: http://kbml.ky.gov/nr/rdonlyres/8766044b-867b-4af9-811f-63a0456ba602/0/telepolicystate.pdf . A health benefit plan shall not exclude a service from coverage solely because the service is provided through telehealth and not provided through a face-to-face consultation if the consultation is provided through the telehealth network. KY. REV. STAT. ANN. § 304.17A-138.	
Louisiana	Board may issue a telemedicine license. Requires reimbursement for telemedicine services.	Telemedicine licenses to allow the practice of medicine across state lines may be issued to an applicant who holds a full and unrestricted license to practice medicine in another state or US territory. The physician thus licensed cannot open an office, meet patients, or receive calls from patients in Louisiana and the physician engaged in telemedicine must establish a bona fide physician-patient relationship. LA. REV. STAT. ANN. §1276.1. A physician who does not hold a license to practice medicine in Louisiana cannot engage in the practice of medicine across state lines in Louisiana via telemedicine unless he or she holds a telemedicine permit issued by the Board. LA. ADMIN. CODE tit. 46, §408(A). Notwithstanding any provision of any policy or contract of insurance or health benefits issued after June 16, 1995 whenever such policy provides for payment, benefit, or reimbursement for any health care service, including but not limited to diagnostic testing, treatment, referral, or consultation, and such health care service is performed via transmitted electronic imaging or telemedicine, such a payment, benefit, or	

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
		<p>reimbursement under such policy or contract shall not be denied to a licensed physician conducting or participating in the transmission at the originating health care facility or terminus who is physically present with the individual who is the subject of such electronic imaging transmission and is contemporaneously communicating and interacting with a licensed physician at the receiving terminus of the transmission. The payment, benefit, or reimbursement to such a licensed physician at the originating facility or terminus shall not be less than seventy-five percent of the reasonable and customary amount of payment, benefit, or reimbursement which that licensed physician receives for an intermediate office visit. LA. REV. STAT. ANN. § 1821(F)(1). No person shall practice or attempt to practice medicine across state lines without first complying with the provisions of this Part and without being a holder of either an unrestricted license to practice medicine in Louisiana or a telemedicine license. LSA-R.S. 37:1271.</p>	
Maine - M	<p>Must obtain a Maine license. Requires reimbursement for telemedicine services.</p>	<p>A carrier offering a health plan in this State may not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would be covered were it provided through in-person consultation. ME. REV. STAT. ANN. tit. 24A, § 4316(2).</p>	<p>In 1999, the Maine Board of Licensure in Medicine and the Maine Board of Osteopathic Licensure adopted the Northeast Region State Medical Boards Statement of Principle, which provides that except for consultation, the provision of all medical services shall require a full license in the state in which the patient encounter will occur.</p>

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
Maine - 0	Must obtain a Maine license.		
Maryland	Must obtain a Maryland license (exception for physicians practicing in adjoining state)	The following individuals may practice medicine without a license: 2) A physician licensed by and residing in another jurisdiction, while engaging in consultation with a physician licensed in this State; 4) A physician who resides in and is authorized to practice medicine by any state adjoining this State and whose practice extends into this State, if: i) the physician doesn't have an office or other regularly appointed place in Maryland to meet patients and the same privileges are extended to licensed physicians Maryland by the adjoining state. Subject to certain exceptions, an individual must be licensed to practice medicine in Maryland in order to practice telemedicine if the physician seeking to practice telemedicine is physically located in Maryland or the patient is in Maryland. MD. CODE REGS. 10.32.03.03.	2012 MD HB 1149 and 2012 SB 781 would require certain insurers, nonprofit health service plans and health maintenance organizations to provide the same coverage for health care services delivered through a telemedicine person as an in-person consultation. Passed April 17, 2012, enactment pending Governor's signature.
Massachusetts	Must obtain a Massachusetts license. Allows reimbursement for telemedicine services	The practice of medicine includes telemedicine. 243 MASS. CODE REGS. 2.01(b). Telemedicine is the provision of services to a patient by a physician from a distance by electronic communication in order to improve patient care, treatment or services. 243 MASS CODE REGS. 2.01. "Telemedicine," as it pertains to the delivery of health care services, shall mean the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Telemedicine shall not include the use of audio-only telephone, facsimile machine or email. See SB 2400.	2012 MA SB 2400 provides that coverage for services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
			doesn't exceed the deductible, copayment or coinsurance applicable to an in-person consultation. Signed by the Governor on 8/6/2012.
Michigan - M	Must obtain a Michigan license. Requires reimbursement for telemedicine services.		2012 MI HB 5408 prohibits a group or nongroup health care corporation from requiring face-to-face contact between a health care provider and a patient for service appropriately provided through telemedicine. Effective 7/18/2012 2012 MI HB 5421 prohibits health maintenance organizations and individual contracts from requiring face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine.

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
			Effective 7/18/2012.
Michigan - O	Must obtain a Michigan license.		
Minnesota	Physician providing telemedicine services to patient in Minnesota must register with the board.	A physician not licensed to practice medicine in Minnesota may provide medical services to a patient located in Minnesota through interstate telemedicine if 1) the physician is licensed without restriction to practice medicine in the state from which the physician provides telemedicine services; 2) the physician has not had a license to practice medicine revoked or restricted in any state or jurisdiction; 3) the physician does not open an office, does not meet with patients, and does not receive calls from patients in Minnesota; and 4) the physician annually registers with the board. MINN. STAT. § 147.032(1).	
Mississippi	Must obtain a Mississippi license.	No person shall engage in the practice of medicine across state lines (telemedicine) in Mississippi, holding him- or herself out as qualified to do the same, or use any title, word or abbreviation to indicate or induce others to believe that he is duly licensed to practice medicine across state lines in this state unless he/she has first obtained a license to do so from the State Board of Medical Licensure and has met all educational and licensure requirements as required by the Board. The aforementioned licensure requirements do not apply where the evaluation, treatment and/or medical opinion to be rendered by a physician outside this state is requested by a physician duly licensed to practice medicine in this state and the physician who has requested such evaluation and treatment and/or medical opinion has already established a doctor/patient relationship with the patient to be evaluated and/or treated. Miss. Code Ann. § 73-25-34.	The Board may grant an examination waiver to foreign licensees meeting certain requirements. MISS. CODE ANN. § 73-25-21.
Missouri	Must obtain a Missouri license.	It is unlawful for any person not now registered as a physician within the meaning of the law to practice medicine or surgery in any of its departments, to engage in the practice of medicine across state lines or to profess to cure and attempt to treat the sick and others afflicted with bodily or mental infirmities, or engage in the practice of midwifery unless an exception applies. MO. REV. STAT. § 334.010. A physician located outside the state isn't required to	

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		obtain a license when: 1) in consultation with a physician licensed to practice in the state; and 2) the physician licensed in Missouri retains ultimate authority and responsibility for the diagnosis or diagnoses and treatment in the care of the patient located in Missouri; or 3) evaluating a patient or rendering an oral, written or otherwise documented medical opinion, or when providing testimony or records for the purpose of any civil or criminal action before any judicial or administrative proceeding in state; or 4) participating in a utilization review. MO. REV. STAT. § 334.010.	
Montana	Board may issue telemedicine license.	Telemedicine licenses may be issued by the board to an applicant who meets all requirements. The license limits the licensee to the practice of telemedicine as defined in these rules and only with respect to the specialty in which the licensee is board-certified or meets the current requirements to take the examination to become board-certified and on which the license bases the application for a telemedicine license. MONT. ADMIN. R. 24.156.802(5). A telemedicine license authorizes an out-of-state physician to practice telemedicine only with respect to the specialty in which the physician is board-certified or meets the current requirements to take the examination to become board-certified and on which the physician bases the physician's application for a telemedicine license. A telemedicine license authorizes an out-of-state physician to practice only telemedicine. A telemedicine license does not authorize the physician to engage in the practice of medicine while physically present within the state. MCA 37-3-343.	
Nebraska	Must obtain a Nebraska license.	Persons who are physically located in another state but who, through the use of any medium, including an electronic medium, perform for compensation any service which constitutes the healing arts that would affect the diagnosis or treatment of an individual located in this state shall be deemed to be engaged in the practice of medicine and surgery. Neb. Rev. St. § 38-2024	
Nevada	Board may issue a special purpose license.	The Board may issue a special purpose license to a physician who is licensed in another state to permit the use of equipment that transfers information concerning the medical condition of a patient in Nevada across state lines electronically, telephonically or by fiber optics. NRS § 630.261(e).	

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
Nevada- O	Must obtain a Nevada license.	An osteopathic physician may engage in telemedicine in this State if he or she possesses an unrestricted license to practice osteopathic medicine in this State pursuant to this chapter. If an osteopathic physician engages in telemedicine with a patient who is physically located in another state or territory of the United States, the osteopathic physician shall, before engaging in telemedicine with the patient, take any steps necessary to be authorized or licensed to practice osteopathic medicine in the other state or territory of the United States in which the patient is physically located. NRS 633.165	
New Hampshire	Must obtain New Hampshire license. Requires reimbursement for telemedicine services.	<p>“Telemedicine” means the use of audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Telemedicine does not include the use of audio-only telephone or facsimile. NH REV. STAT. § 415-J:2(III).</p> <p>An insurer offering a health plan in NH cannot deny coverage solely because the coverage is provided through telemedicine if the health care service would be covered if it were provided through in-person consultation between the covered person and the health care provider. NH REV. STAT. § 415-J:3(II).</p> <p>“Physicians providing care and/or treatment to patients in New Hampshire must be licensed in New Hampshire... Thus, an out-of-state doctor using telemedicine or the internet to diagnose and treat a patient residing in NH must have a NH license or be acting as a consultant to a NH physician who has a bona fide physician-patient relationship with the patient. A physician located outside NH isn’t required to obtain a license when: 1) in consultation with a physician licensed to practice medicine in this state who has a bona fide doctor-patient relationship with the patient and 2) the physician licensed in this state retains the ultimate authority and responsibility for the diagnosis and treatment in the care of the patient located in NH. See policy statement at: http://www.nh.gov/medicine/aboutus/prescribing.htm.</p>	
New Jersey	Must obtain New Jersey license (exception for physician taking temporary charge of a patient upon	Licensure is not required if physician is: A lawfully qualified physician or surgeon of another state taking charge temporarily, on written permission of the board, of the practice of a lawfully qualified physician or surgeon of this State during his absence from the State, upon written request to the board for permission so to do. Before such permission is granted by the board and before any person may	

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
	written permission of the board).	enter upon such practice he must submit proof that he can fulfill the requirements demanded in the other sections of this article relating to applicants for admission by examination or endorsement from another state. Such permission may be granted for a period of not less than two weeks nor more than four months upon payment of a fee of \$50. The board in its discretion may extend such permission for further periods of two weeks to four months but not to exceed in the aggregate one year. NJ STAT. ANN. § 45:9-21(b). A physician or surgeon of another state of the United States and duly authorized under the laws thereof to practice medicine or surgery therein, if such practitioner does not open an office or place for the practice of his profession in this State. NJ STAT. ANN. § 45:9-21(c).	
New Mexico - M	Board may issue a telemedicine license.	“Telemedicine” means the practice of medicine across state lines. The practice of medicine across state lines means the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of a patient within this state by a physician located outside this state as a result of transmission of individual patient data by electronic, telephonic or other means from within this state to the physician or the physician’s agent, OR the rendering of treatment to a patient within this state by a physician located outside this state as a result of transmission of individual patient data by electronic, telephonic or other means from within this state to the physician or the physician’s agent. NM STAT. ANN. 1978 § 61-6-6. A telemedicine license allows for the practice of medicine across state lines to an applicant who holds a full and unrestricted license to practice in another state or territory of the United States. NM STAT. ANN. 1978 § 61-6-11.1. Any person who practices medicine across state lines or who attempts to practice medicine across state lines without first complying with the provisions of the Medical Practice Act and without being the holder of a telemedicine license entitling him to practice across state lines is guilty of a fourth degree felony. NM STAT. ANN. 1978 § 61-6-20(B).	
New Mexico - O	Must obtain a New Mexico license.		

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
New York	Must obtain a New York license.		
North Carolina	Must obtain a North Carolina license.	<p>Any person so practicing without being duly licensed and registered in this State and who is an out-of-state practitioner shall be guilty of a Class I felony. NC GEN. STAT. ANN. § 90-18(a). "Telemedicine" is the practice of medicine using electronic communication, information technology or other means between a licensee in one location and a patient in another location with or without an intervening health care provider... The practice of medicine is deemed to occur in the state in which the patient is located. Therefore, any licensee using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina. See policy statement at: http://www.ncmedboard.org/position_statements/detail/telemedicine/. (a) The Board may issue a special purpose license to practice medicine to an applicant who: (1) Holds a full and unrestricted license to practice in at least one other jurisdiction; and (2) Does not have any current or pending disciplinary or other action against him or her by any medical licensing agency in any state or other jurisdiction. (b) The holder of the special purpose license practicing medicine or surgery beyond the limitations of the license shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less than twenty-five dollars (\$25.00) nor more than fifty dollars (\$50.00) for each offense. The Board, at its discretion, may revoke the special license after due notice is given to the holder of the special purpose license. (c) The Board may adopt rules and set fees as appropriate to implement the provisions of this section. NCGSA § 90-12.2A</p>	Board does provide for expedited licensure if certain eligibility requirements are met.
North Dakota	Must obtain a North Dakota license.		

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
Ohio	Board may issue telemedicine certificate (and subsequent special activity certificate).	<p>"The practice of telemedicine" means the practice of medicine in this state through the use of any communication, including oral, written, or electronic communication, by a physician located outside this state." OH. REV. CODE ANN. § 4731.296(A). The holder of a telemedicine certificate may engage in the practice of telemedicine in this state. A person holding a telemedicine certificate shall not practice medicine in person in this state without obtaining a special activity certificate. OH. REV. CODE ANN. § 4731.296(C). When a person licensed to practice medicine and surgery or osteopathic medicine and surgery by the licensing department of another state, a diplomate of the national board of medical examiners or the national board of examiners for osteopathic physicians and surgeons, or a licentiate of the medical council of Canada wishes to remove to this state to practice, the person shall file an application with the state medical board. The board may, in its discretion, by an affirmative vote of not less than six of its members, issue its certificate to practice medicine and surgery or osteopathic medicine and surgery without requiring the applicant to submit to examination, provided the applicant submits evidence satisfactory to the board. OH. REV. CODE § 4731.29(A)</p> <p>Licensees using telemedicine technologies to provide care to patients located in Ohio must provide an appropriate examination prior to diagnosing and/or treating the patient. The examination need not be in-person if the technology is sufficient to provide the same information to the licensee as if the exam had been performed face-to-face.</p> <p>http://med.ohio.gov/pdf/NEWS/Position%20Statement%20on%20Telemedicine Approved%20May%2010.%202012.pdf.</p>	
Oklahoma - M	Must be licensed in Oklahoma. Requires reimbursement for telemedicine services.	<p>"Telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment including but not limited to, the treatment and prevention of strokes, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. OKLA. STAT. ANN. tit. 36, § 6802. Health care service plans, disability insurer programs, workers' compensation programs, or state Medicaid managed care program contracts issued, amended, or renewed on or after January 1, 1998, shall not require person-to-person contact between a health care practitioner and a patient.</p>	Board has adopted a telemedicine policy in an effort to improve access to mental health care services in Oklahoma. See policy statement at: http://www.okm

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
		OKLA. STAT. ANN. tit. 36, § 6803.	edicalboard.org/download/497/Adopted Telemedicine Policy 9 18 08.pdf . Full licensure required unless physician is rendering emergency advice or opinion or when the physician accepts or expects no compensation. See policy statement: http://www.okmedicalboard.org/download/498/Telmedicine Licensure Requirement s.pdf .
Oklahoma - O	Effective Nov. 1 2013, Board may issue a telemedicine license.		
Oregon	Board may issue license to practice medicine across state lines. Requires reimbursement for telemedicine services.	Telemedicine is the use of telephonic or electronic communications to medical to move medical information from one sit to another to improve a patient's health status. OR. ADMIN. R. 410-130-0610(1). A referring and evaluating practitioner must be licensed to practice medicine within the state of Oregon or within the contiguous area of Oregon and must be enrolled as a Division of Medical Assistance Program (Division) provider. OR. ADMIN. R. 410-130-0610(3)(a). Upon application, the board may issue to an out-of-state physician a license for the practice of medicine across state lines if the physician holds a full, unrestricted license to practice medicine in any other state, has not been sanctioned and otherwise meets the requirements for licensure. OR. REV. STAT. ANN. § 677.139 A health benefit plan must provide coverage of a telemedicine health service if the plan provides coverage of the health	

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		service when provided in person by the health professional, the health service is medically necessary and the health service does not duplicate or supplant a health service that is available to the patient in person. OR. REV. STAT. ANN. § 743A.058(2).	
Pennsylvania - M	Must obtain a Pennsylvania license (some exceptions exist for physicians near state lines)	An extraterritorial license empowers the licensee residing in or maintaining the office of practice in any adjoining state near the boundary line between such state and this Commonwealth, whose medical practice extends into this Commonwealth, to practice medicine and surgery with or without restriction in this Commonwealth on such patients...The exercise of discretion of the board in granting such a license will depend on the needs of the patients in Pennsylvania, the availability of medical care in the area involved and whether the adjoining state extends similar privileges to Pennsylvania physicians. 63 PENN. STAT. ANN. § 422.34(a) and (c)(2).	Governor announced on May 23rd that telemedicine services covered by the Pennsylvania Medical Assistance (Medicaid) program: http://www.sacbee.com/2012/05/22/4509091/pennsylvania-governor-corbett.htm .
Pennsylvania - O	Must obtain a Pennsylvania license (some exceptions exist for physicians near state lines)	A duly licensed physician residing in or maintaining his office of practice in a state near the boundary line between said state and Pennsylvania whose practice extends into Pennsylvania will have the right to practice in Pennsylvania at the discretion of the board, provided he files a certified copy of his license and that the board in the adjoining state reciprocates by extending the same privilege to physicians in Pennsylvania. 63 PENN. STAT. ANN. § 271.10(a).	
Rhode Island	Must obtain a Rhode Island license.	Any person who is not lawfully authorized to practice medicine in this state and registered according to law who practices medicine or surgery or attempts to practice medicine or surgery or attempts to practice medicine or surgery, or any of the branches of medicine or surgery, after having received or with the intent of receiving, either directly or indirectly, any bonus, gift or compensation, or who opens an office with intent to practice medicine, or holds himself or herself out to the public as a practitioner of medicine, whether by appending to his or her name the title of doctor or any abbreviation, or M.D., or any other title or designation implying a practitioner of medicine, or in any other way, shall be imprisoned not more than three (3) years, or fined	

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
		not more than one thousand dollars (\$1,000), or shall suffer both fine and imprisonment; and in no case when any provision of this chapter has been violated shall the person violating these provisions be entitled to receive compensation for services rendered. RI GEN. LAWS § 5-37-12. Nothing in the Medical Practice Act shall be construed to authorize any itinerant doctor to register or to practice medicine in any part of this state. Gen. Laws § 5-37-3.	
South Carolina	Must obtain a South Carolina license.	The Board adheres to the view that the practice of medicine occurs where the patient is physically located, therefore, the physician must be licensed in that state. This position is consistent with the purpose of state licensure requirements, which is to protect the members of the public in the state, and it is the position followed by most other state medical boards that have considered the question...Therefore, the Board holds that an out-of-state physician who performs an act that constitutes the practice of medicine on a patient physically located in this state is practicing medicine, as defined by state law, and must be licensed in South Carolina. See policy statement at http://www.llr.state.sc.us/POL/Medical/index.asp?file=Polices/MEPRIMDIAG.HTM .	
South Dakota	Must obtain a South Dakota license.	Any nonresident physician or osteopath who, while located outside South Dakota, provides diagnostic or treatment services through electronic means to a patient located in this state under a contract with a health care provider licensed under Title 36, a clinic located in this state that provides health services, a health maintenance organization, a preferred provider organization, or a health care facility licensed under chapter 34-12, is engaged in the practice of medicine or osteopathy in this state. SD CODIFIED LAWS § 36-4-41. Nothing contained in this chapter shall be construed to apply to any licensed person practicing any of the healing arts outside of this state when in actual consultation with a licensed practitioner of the healing arts in this state. SD CODIFIED LAWS § 36-2-9.	
Tennessee - M	Board may issue a telemedicine license.	No person shall engage in the practice of medicine across state lines in this State, hold himself out as qualified to do the same, or use any title, word, or abbreviation to indicate to or induce others to believe that he is licensed to practice medicine across	

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
		<p>state lines in this State unless he is actually so licensed in accordance with the provisions of this rule. TENN. COMP. R. & REGS. 0880-02-.16. The practice of medicine across state lines (telemedicine) means either 1) the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of a patient within this State by a physician located outside this State as a result of transmission of individual patient data by electronic or other means from within this State to such physician or his agent; or 2) the rendering of treatment to a patient within this State by a physician located outside this State as a result of transmission of individual patient data by electronic or other means from within this State to such physician or his agent. TENN. COMP. R. & REGS. 0880-02-.16(1). An applicant who has an unrestricted license in good standing in another state and maintains an unencumbered certification in a recognized specialty area; or is eligible for such certification and indicates a residence and a practice outside the State of Tennessee but proposes to practice medicine across state lines on patients within the physical boundaries of the State of Tennessee, shall in the discretion of the Board be issued a telemedicine license. Tenn. Comp. R. & Regs. 0880-02-.16(b). The board has the authority to issue restricted licenses and special licenses based upon licensure to another state for the limited purpose of authorizing the practice of telemedicine to current applicants or current licensees, or both, as it deems necessary. TCA § 63-6-209(b).</p>	
Tennessee - O	Board may issue a telemedicine license.	<p>No person shall engage in the practice of osteopathic medicine across state lines in this State, hold himself out as qualified to do the same, or use any title, word, or abbreviation to indicate to or induce others to believe that he is licensed to practice medicine across state lines in this State unless he is actually so licensed in accordance with the provisions of this rule. TENN. COMP. R. & REGS. 1050-02-.17. The practice of osteopathic medicine across state lines (telemedicine) means either 1) the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of an osteopathic patient within this State by a osteopathic physician located outside this State as a result of transmission of individual patient data by electronic or other means from within this State to such physician or his</p>	

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
		agent; or 2) the rendering of treatment to a patient within this State by an osteopathic physician located outside this State as a result of transmission of individual patient data by electronic or other means from within this State to such osteopathic physician or his agent. TENN. COMP. R. & REGS. 1050-02-.17(1). Issuance of License - An applicant who has an unrestricted license in good standing in another state and maintains an unencumbered certification in a recognized specialty area; or is eligible for such certification and indicates a residence and a practice outside the State of Tennessee but proposes to practice osteopathic medicine across state lines on patients within the physical boundaries of the State of Tennessee, shall in the discretion of the Board be issued a telemedicine license. TN ADC 1050-02-.17.	
Texas	Board may issue telemedicine license to out-of-state physicians. Requires reimbursement for telemedicine services.	Physicians who treat and prescribe through advanced communications technology are practicing medicine and must possess appropriate licensure in all jurisdictions where their patients presently reside. An out-of-state physician may provide episodic consultations without a Texas medical license, as provided in Texas Occupations Code, § 151.056 and § 172.12(f) of this title (relating to Out-of-State Telemedicine License-Exemptions). 22 TEX. ADMIN. CODE § 174.12. A health benefit plan may not exclude a telemedicine medical service or a telehealth service from coverage under the plan solely because the service isn't provided through a face-to-face consultation. A health benefit plan may require a deductible, copayment or coinsurance for a telemedicine medical service or a telehealth service but the amount cannot exceed the amount of the deductible, copayment or coinsurance required for a comparable medical service provided through a face-to-face consultation. TEX. INS. CODE ANN. § 1455.004. Physicians who treat and prescribe through advanced communications technology are practicing medicine and must possess appropriate licensure in all jurisdictions where their patients presently reside. An out-of-state physician may provide episodic consultations without a Texas medical license, as provided in Texas Occupations Code, § 151.056 and § 172.12(f) of this title (relating to Out-of-State Telemedicine License-Exemptions). 22 TAC § 174.22.	
Utah - M	Must obtain a	The following individuals may engage in the	

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
	Utah license.	described acts or practices without being licensed under this chapter: an individual engaging in the practice of medicine when: (a) the individual is licensed in good standing as a physician in another state with no licensing action pending and no less than 10 years of professional experience; (b) the services are rendered as a public service and for a noncommercial purpose; (c) no fee or other consideration of value is charged, received, expected, or contemplated for the services rendered beyond an amount necessary to cover the proportionate cost of malpractice insurance; and (d) the individual does not otherwise engage in unlawful or unprofessional conduct.	
Utah - O	Must obtain a Utah license.		
Vermont - M	Must obtain a Vermont license.		2011 VT HB 37 would require all health insurance plans in Vermont to provide coverage for telemedicine services to the same extent the services would be covered if they were provided through an in-person consultation. Passed legislature on 4/28/2012, enactment pending Governor's signature.
Vermont - O	Must obtain a Vermont license		
Virginia	Must obtain a	An insurer, corporation, or health maintenance	

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
	Virginia license. Requires reimbursement for telemedicine services	organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services. VA CODE ANN. § 38.2-3418.16(C).	
Washington - M	Must obtain a Washington license.	[The Medical Practice Act] does not prohibit the practice of medicine by any practitioner licensed by another state or territory in which he or she resides, provided that such practitioner shall not open an office or appoint a place of meeting patients or receiving calls within the state. RCWA 18.71.030	
Washington - O	Must obtain a Washington license.	[The Medical Practice Act] does not prohibit the practice of medicine by any practitioner licensed by another state or territory in which he or she resides, PROVIDED that such practitioner shall not open an office or appoint a place of meeting patients or receiving calls within the state. RCWA 18.57.040.	
West Virginia - M	Must obtain a West Virginia license.	A person may not engage in the practice of medicine and surgery or podiatry, hold himself or herself out as qualified to practice medicine and surgery or podiatry or use any title, word or abbreviation to indicate to or induce others to believe that he or she is licensed to practice medicine and surgery or podiatry in this state unless he or she is actually licensed under the provisions of this article. A person engaged in the practice of telemedicine is considered to be engaged in the practice of medicine within this state and is subject to the licensure requirements of this article. As used in this section, the term “practice of telemedicine” means the use of electronic information and communication technologies to provide health care when distance separates participants and includes one or both of the following: (1) The diagnosis of a patient within this state by a physician located outside this state as a result of the transmission of individual patient data, specimens or other material by electronic or other means from within this state to the physician or his or her agent; or (2) the rendering of treatment to a patient within this state by a physician located outside this state as a result of transmission of individual patient data, specimens or other material by electronic or other means from within this state to the physician or his or her agent. No person may practice as a physician assistant, hold himself or	

State	Type of License Required	Legislation/Regulation/Policy Guidelines	Pending Legislation/ Notes
		herself out as qualified to practice as a physician assistant or use any title, word or abbreviation to indicate to or induce others to believe that he or she is licensed to practice as a physician assistant in this state unless he or she is actually licensed under the provisions of this article. W. Va. Code, § 30-3-13. The unauthorized practice of medicine does not apply to an individual physician or podiatrist, or physician or podiatrist groups, or physicians or podiatrists at a tertiary care or university hospital outside this state and engaged in the practice of telemedicine who consult or render second opinions concerning diagnosis or treatment of patients within this state: (i) In an emergency or without compensation or expectation of compensation; or (ii) on an irregular or infrequent basis which occurs less than once a month or less than twelve times in a calendar year. W. Va. Code § 30-3-13(d)(3).	
West Virginia - O	Must obtain a West Virginia license		
Wisconsin	Must be licensed in Wisconsin.		
Wyoming	Must be licensed in Wyoming.	"Telemedicine" means the practice of medicine by electronic communication or other means from a physician to a location to a patient in another location, with or without an intervening health care provider. WYO. STAT. ANN. § 33-26-102(xxix).	

For informational purposes only: This document is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Non-cited laws, regulation, and/or policy could impact analysis on a case-by-case or state-by-state basis. All information should be verified independently.

End quoted text

Appendix F: Task Force 2013 Meeting Schedule

Maryland law requiring MHCC to reconvene the task force went into effect on July 1, 2013.⁴⁹ The first 2013 task force meeting was held on July 24th and included a joint session of all three task force advisory groups. Following the joint session, the Clinical Advisory Group and Technology Solutions and Standards Advisory Group met roughly monthly through November 2013. The Finance and Business Model Advisory Group will reconvene in early 2014.

Joint Session

Wednesday, July 24, 10:00 a.m. - 12:00 p.m.

Clinical Advisory Group

Thursday, August 22, 1:00 p.m. - 3:00 p.m.

Monday, September 23, 10:15 a.m. - 12:15 p.m.

Thursday, October 24, 10:00 a.m. - 12:00 p.m.

Monday, November 18, 10:00 a.m. - 12:00 p.m.

Technology Solutions and Standards Advisory Group

Wednesday, August 14, 9:30 a.m. - 11:30 a.m.

Wednesday, September 11, 3:00 p.m. - 5:00 p.m.

Thursday, October 10, 10:00 a.m. - 12:00 p.m.

Tuesday, November 5, 3:00 p.m. - 5:00 p.m.

⁴⁹ *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session). Available at: http://mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.

Appendix G: MHCC State Telemedicine Network Environmental Scan

The MHCC conducted an environmental scan to assess statewide telemedicine networks in the U.S.; Ontario's telemedicine network is also included.⁵⁰ The assessment provides an overview of several telemedicine networks and also indicates successful aspects and key messages for Maryland. The following states are included in the assessment: Arizona, California, Colorado, Georgia, Maine, Missouri, Nebraska, New Mexico, Utah, Virginia, and Wyoming, along with Ontario, Canada.

ARIZONA: Arizona Telemedicine Program (university-based)

<http://www.telemedicine.arizona.edu/app/home>

Organization Description

The Arizona Telemedicine Program (ATP) is operated by the University of Arizona. The university designed the telecommunications system in a configuration that minimized telecommunications charges, installed the telecommunications equipment, and operates the entire network. The network spans the entire state and is linked to other telecommunication networks in Arizona.

Inception and Funding

In 1996, the Legislature of the State of Arizona funded the ATP. Leveraging the state startup funds, the program obtained additional funding and support from healthcare systems, state agencies, federal grant programs, and third party payors. ATP participants and members of affiliated programs have competed for grants and contracts totaling over \$14 M.

Partners

Hospitals, medical centers, community health centers, counseling centers, schools, Arizona Department of Corrections, Arizona State Prison Complex, Arizona Department of Health Services Children's Rehabilitative Services (CRS).

Services

The program offers clinical, educational, and administrative services, as well as research supporting the end-to-end assessment of telemedicine—from video imaging, networks, picture archiving and communication systems to end-user equipment and appliances. ATP provides medical services via both real-time and store-and-forward technologies in twenty communities. Services include disease prevention, public education, correctional telemedicine, children's healthcare, home health care and nursing, occupational and physical therapy, and telenursing in schools. The Arizona Diabetes Virtual Center of Excellence (ADVICE) is a comprehensive program for diabetes prevention, assessment, and management. ADVICE offers training and education and teleconsultation with specialists. ATP also serves as an information clearinghouse and resource center for telemedicine in the state, including oversight of grants applications.

⁵⁰ MHCC, *Telemedicine Statewide Networks - Environmental Scan*, October 2013. Available at: http://mhcc.dhmd.maryland.gov/hit/telemedicine/Documents/telemedicine_%20networks_v3_revised_082813.pdf.

Membership and Fees

The program charges a membership fee to participating providers on a sliding scale based upon services desired. The program centralized the application process for rebates from the federal Universal Service Fund's Rural Health Care Program, which helps rural health care providers acquire telecommunications and Internet services. Arizona providers have received over \$2.6M in rebates to support telemedicine.

Technology, Equipment, and Vendors

ATP has a Private Network Interface between the Arizona telemedicine communications network and its member sites. Any network member site can interact with other providers of services using the ATP Network with the understanding that all providers utilizing the network must have a membership agreement with ATP. However, member sites are responsible for contacting other sites that they wish to interact with in advance to assure compatibility of equipment, and to arrange scheduling of facilities and staff. No member site is in any way required to so participate. ATP's Project Nightingale, has a dedicated broadband healthcare infrastructure which functions as a telecommunications collaborative providing access to T-1/ATM telecommunications on a private network throughout the state on a cost-sharing basis.

Successful Aspects

Offer rebates to rural providers to help them adopt telemedicine. Comprehensive diabetes program. Strong focus on research and technology transfer.

Key Messages for Maryland

State worked with a federal program to streamline the application process for rebates to rural health care providers for telecommunications and Internet services. Providers have received over \$2.6M in rebates.

CALIFORNIA: California Telehealth Network (non-profit)

<http://www.caltelehealth.org>

Organization Description

The California Telehealth Network (CTN) is a non-profit agency with a broadband network that supports the interconnection of hospitals, clinics, physicians, health departments, and schools. Institutions are connected together through a high speed network to academic centers, data centers, application service providers, and insurers.

Inception and Funding

CTN began in 2007. Coalition of healthcare, technology and governmental agencies requested funding from the FCC to expand broadband throughout California's rural and underserved areas. The FCC Rural Health Care Pilot Project (RHCPP) awarded \$22.1 million to California to install broadband services and develop a medical grade telecommunications network. The California Emerging Technology Fund and UnitedHealth/PacifiCare provided matching funds. The University of California provided in-kind support.

Partners

Medical centers, community health centers, rural health clinics, hospitals, United Indian Health Services.

Services

24/7 tech support and help desk. Point to point access to all members. Bridge services to connect multiple locations for meetings and education. Access to telehealth program development and technical assistance through federally designated Telehealth Resource Center, CTEC. Matching patient sites with available telehealth providers. Access to: public Internet (through the Corporation for Education Network Initiative in California-CENIC); Internet2 and national LambdaRail; national healthcare databases and disease registries; educational programming for clinical staff; patient education programs. Hosting for electronic health records. Webinars and training. Equipment discounts.

Membership and Fees

All health organizations can become members of CTN and obtain broadband services by subscription. Over 800 rural and underserved health care sites in California applied and were qualified by the FCC under the Rural Health Pilot Project to receive a subsidy for monthly subscription fees. Free telehealth training for member sites.

Technology, Equipment, and Vendors

High speed, medical grade, HIPPA compliant broadband from 1.5 mgbs-45 mgbs. CTN conducted a competitive procurement. AT&T was selected as the vendor to install broadband circuits and individual site routers for the 800 Pilot Project Sites.

Successful Aspects

CTN is widely expanding broadband access for the state and developing a medical grade telecommunications network.

Key Messages for Maryland

CTN began their efforts by building the telecommunications infrastructure in the state. The technology services offered include telehealth.

COLORADO: Colorado Telehealth Network (consortium)

<http://www.cotelehealth.com>

Organization Description

The Colorado Telehealth Network (CTN) provides broadband connections for Colorado's health care delivery systems. CTN provides a dedicated, secured network with essential connection capabilities for health care data, medical images, and electronic health records.

Inception and Funding

CTN was formed in 2008 by the Colorado Hospital Association and the Colorado Behavioral Health Council as a result of two FCC grants. Network resulted from a \$10.7 million federal Universal Service Fund award to develop a dedicated, statewide health care broadband network.

Partners

More than 200 participating health care providers across Colorado, including hospitals, clinics, behavioral health centers, and an HIE. Majority of member sites are rural.

Services

Low-cost, high-capacity digital bandwidth for enhanced communications systems, including use of electronic health records, televideo, telephone services using the Internet (VoIP), and transmission of high-resolution images in trauma situations.

Membership and Fees

High-capacity connection to more than 200 health care sites for cost of a single connection.

Technology, Equipment, and Vendors

Connectivity between participating providers and to the Internet and Internet2 via private broadband network. Core services (shared infrastructure) include encryption and advanced routing services.

Successful Aspects

Potential for increased referrals from and consults to organizations not currently in a provider's referral network.

Key Messages for Maryland

Network is partnered with the a statewide health information exchange: Colorado Regional Health Information Organization (CORHIO).

GEORGIA: Georgia Partnership for Telehealth (non-profit)

<http://www.gatelehealth.org>

Organization Description

The goal of the Georgia Partnership for Telehealth (GPT) is to allow all Georgians to have access to specialty consultations without having to travel more than 30 miles from their homes. The program had over 25,000 patient encounters in 2010. More than 175 specialists and health care providers participate, representing over 40 specialties. Georgia's prison system makes heavy use of the technology, saving the department over 30 percent in medical costs.

Inception and Funding

GPT is a charitable non-profit corporation funded through public and private sources. The statewide Georgia Telemedicine Program began in 2005 through a grant from WellPoint, Inc. Negotiations with Commissioner Oxendine for Anthem and WellPoint Merger resulted in the Rural Health Initiative and \$100M over the next 20 years in rural capital bonds and \$11.5 M in over 3

years for a Statewide Telemedicine Program. The GPT was formed in 2008 to continue the successes of the telemedicine program after Wellpoint's 3 year commitment.

Partners

Hospitals, medical centers, community sites, schools, skilled nursing facilities, specialty sites, tele-trauma and stroke sites, corrections.

Services

Services in primary care, trauma, nursing, mental health, child advocacy, school systems, continuing education, consultative services in network design, and telemedicine development and implementation. The program includes centralized scheduling of specialist consultants using a website that tracks open appointment times for panel specialists, so that consults can be requested and scheduled efficiently. GPT has a network of primary and remote stroke treatment centers. Providers are required to be fully licensed in the state of Georgia.

Membership and Fees

Information not provided

Technology, Equipment, and Vendors

GPT is based on the Open Access Network, a web of access points formed by leveraging existing telemedicine programs in the state and creating access points at additional locations.

Successful Aspects

Active telemedicine network that includes a centralized scheduling service for specialty consultations.

Key Messages for Maryland

Savings in medical costs attributable to use of telemedicine by the prison system (departmental savings of over 30 percent in medical costs).

MAINE: Maine Telemedicine Services (non-profit)

<http://mainetelemedicine.org>

Organization Description

Maine Telemedicine Services (MTS) uses video conferencing for administrative, educational, social service, and clinical telemedicine.

Inception and Funding

The Governor's Office and the Maine Health Access Foundation, an independent charitable corporation that has provided over \$40 million in grants and program support, have been partners to the MTS in expanding telemedicine.

Partners

MTS partners with the Eastern Maine Health Care Systems Telehealth Network and the MaineHealth eICU VitalNetwork, as well as state governmental entities such as the Departments of

Health and Human Services and Corrections. The network includes over 300 facilities including hospitals, health centers, mental health and social service agencies, nursing homes, community programs, child care centers, and government.

Services

MTS projects include mental health and psychiatry efforts, expanding telemedicine access among correctional and youth correctional facilities, judicial videoconferencing, telepharmacy, home telehealth care (especially mental health care for elders with depression and anxiety), island health care (connecting residents of remote islands along the coast to specialists), video relay (American Sign Language) interpreting services, health care education for doctors and nurses (such as Grand Rounds CME), state telemedicine infrastructure development, and helping other states plan telemedicine programs.

Membership and Fees

Telemedicine equipment and installation at lower prices than commercial vendors. Service contracts on Polycom telemedicine equipment at greatly reduced rates. Discounted ISDN line costs and support with telephone company. Discounted bridging services for multipoint teleconferencing through MTS bridge.

Technology, Equipment, and Vendors

Open, interoperable statewide network. A video bridge for linking multiple users. In addition to live video conferencing, all video units within the network have the capability of running PowerPoint, VHS and DVD presentations to other sites.

Successful Aspects

Exploring a variety of use cases for telemedicine, including correctional, judicial, pharmacy, and home health.

Key Messages for Maryland

Provide assistance to other states planning telemedicine programs.

MISSOURI: Missouri Telehealth Network (public-private partnership)

<http://medicine.missouri.edu/telehealth>

Organization Description

The Missouri Telehealth Network (MTN) enhances access to care for underserved areas of Missouri, delivers education for providers, furthers homeland security for disaster preparedness, and provides research opportunities to clinicians to study via telehealth. MTN has over 202 sites in 62 Missouri counties. In FY2010 a total of 6,703 trips were avoided due to telemedicine, totaling 245,608 miles with cost savings of \$662,285 for patients.

Inception and Funding

MTN began in 1994 as a public-private partnership. A ten site network was developed with federal support from HRSA's Office of Rural Health Policy and private support from telecommunication

companies, as well as each telehealth site. The network is now funded with federal, state, and institutional dollars, including financial support from MTN sites.

Partners

The MTN network consists of hospitals, federally qualified health centers, community mental health centers, a state habilitation center, critical access hospitals, community hospitals, rural health clinics, and other health care facilities.

Services

MTN has provided services in radiology, mental health, dermatology, and cardiology. In 2011, 69 medical professionals in 29 specialties conducted over 15,386 encounters via video on the MTN. MTN provides: training for start up telemedicine programs in clinical, technical, operational, and legal and regulatory areas. It also provides technical assistance to telehealth networks; business and strategic planning; evaluation of satisfaction, cost analysis, concordance in diagnosis and treatment of various telehealth modalities; telehealth policy activities; educational outreach; and information dissemination. MTN provides an average of 340 Interactive Telehealth Encounters and 720 Teleradiology Exams per month.

Membership and Fees

MTN members can be Full or Affiliate. A full membership is physically connected to the MTN backbone where affiliate members use the public internet for their video connection.

Technology, Equipment, and Vendors

MTN has a 2 gigabit backbone infrastructure on the MOREnet secure network. This network connects to the Internet via a high-speed intrastate network of six major circuits connecting several major population centers. The six major circuits form the network backbone. MTN sites use the backbone to connect to each other. The MTN uses a semi private network using the Internet Protocol (IP) to deliver two way interactive audio and video for clinical encounters, and data transfer for teleradiology and other store and forward services. The MTN uses T1 (Frame Relay) connections to each site providing dynamic bandwidth allocation for voice, video, and data. MTN sites have the flexibility to call any other MTN site directly in this configuration.

Successful Aspects

An active network with regular telemedicine encounters between network partners. Experience with a number of telemedicine use cases, including radiology, mental health, dermatology, and cardiology.

Key Messages for Maryland

Data on cost savings for patients based on avoided travel. In FY2010, cost savings of \$662,285 for patients.

NEBRASKA: Nebraska Statewide Telehealth Network (collaboration of over 110 sites)

<http://www.netelehealth.net>

Organization Description

The Nebraska Statewide Telehealth Network (NSTN) is a statewide secure communications network capable of supporting real-time video-conferencing and communications, data transmission, and telehealth services.

Inception and Funding

The FCC Rural Health Program administered by the Universal Services Administrative Company (USAC) provides funding to eligible rural sites to offset costs of connectivity. The Nebraska Public Service Commission provides up to \$900,000 per year in support--this funding is available to all not-for-profit urban and rural hospitals and assists in paying for connectivity costs and equipment costs (such as routers, firewalls and bridges). Participating hospitals in rural areas each contribute a minimum of \$100 per month for transmission costs.

Partners

Collaboration of over 110 sites, including hospitals, health departments, mental health centers, physician offices, and rural health clinics.

Services

Clinical consultation, support groups, education, and training and connectivity for administrative meetings. Health care professionals can perform physical examinations through the system, using specialized cameras, electronic stethoscopes, and other medical peripheral devices. Network is also designed to improve the readiness of the State to deal with terrorist acts and threats, naturally-occurring disasters, and issues of public health concern by allowing instant communication between the Lt. Governor, the Chief Medical Officer and physicians, hospitals, public health departments, and public health laboratories.

Membership and Fees

A member has a permanent technological connection to the network. This connection is always engaged and the organization can use it at any time. The NSTN does not assess a membership fee, but members do pay a fee to telecommunications providers for connection to the network.

Technology, Equipment, and Vendors

Private network. Spoke and hub with all hubs connected to backbone that runs length of state. Backbone lines are comprised of bundled T-1s. 26 backbone lines are in place. Each spoke site is connected by a T-1 line, a fiber line or microwave technology to its hub site. Users can connect to other entities outside the network via internet through secure bridge connections, but NSTN is not designed to be a telecommunications provider of voice over IP or internet. Network spoke sites receive assistance in connection from their hub sites, esp for meetings with multiple sites; but any site can connect to any site in the network. All network sites employ routers with firewall and have one or more cameras. Seven of eight hub sites have bridges for multi-point connectivity. Some sites employ peripheral devices. All hub sites have more than one camera for many interactions to

take place simultaneously. Many endpoint hospitals have more than one camera: one for clinical, administrative, and educational sessions and one in the emergency department for teleemergency.

Successful Aspects

A well-developed network designed specifically for telemedicine consultations with advanced services to perform physical examinations.

Key Messages for Maryland

Considerable detail regarding their network technology and equipment could be instructive.

NEW MEXICO: New Mexico Telehealth Alliance (non-profit)

<http://www.nmtelehealth.org>

Organization Description

The New Mexico Telehealth Alliance is a network of public and private healthcare organizations providing technical and program support to members to ensure coordinated telehealth services.

Inception and Funding

Information not provided. (Board members, officers, and executive director are volunteers)

Partners

LCF Research, NM Association for Home & Hospice Care, NM Center for Telehealth, NM Coalition for Health Care Leadership Initiatives, NM Health Resources, NM Medical Review Association, NM Primary Care Association, RHIO Grande, Sangre de Cristo Community Health Partnership, The Wellness Coalition, University of New Mexico Center for Telehealth

Services

Clinical Coordination: Identifying healthcare delivery needs, finding organizations to deliver healthcare services, and monitoring the delivery. Technical Coordination: Identifying the proper technical solution for healthcare service delivery including equipment evaluation, telecommunications connectivity, reuse of existing resources, scheduling, network management, support, and maintenance. Health Information Technology: Managing information exchange among healthcare providers and ensuring compliance with federal, state, and other standards. Administrative Services: Reimbursement issues, administrative policy and procedures, and legislative issues.

Membership and Fees

Information not provided.

Technology, Equipment, and Vendors

The alliance is working with an Australian vendor to bring a remote monitoring kiosk into New Mexico for testing and preliminary deployment. The device will enable physicians to monitor patient parameters such as pulse, blood pressure, and glucose level without an office visit. Likely sites for the devices include senior centers, senior living and assisted living facilities, and community centers. The alliance is also in discussions with Technet and PNM regarding use of the

PNMs high-speed network for monitoring power stations and transformers. The network extends through much of the state and has excess capacity that could be used for telehealth and other applications.

Successful Aspects

Exploring physical examination devices to remotely monitor patients' pulse, blood pressure, glucose levels.

Key Messages for Maryland

Focus is on coordinating the various telehealth initiatives in the state.

UTAH: Utah Telehealth Network (university-based program)

<http://www.utahtelehealth.net>

Organization Description

The Utah Telehealth Network (UTN) uses interactive video to deliver patient care, provide continuing education to health professionals, and facilitate administrative meetings.

Inception and Funding

Utah Arches project awarded over \$9 million by the FCC to participate in the Rural Health Care Pilot Program to facilitate a nationwide broadband network dedicated to healthcare. Over \$1.5 million in additional funds provided by partners, participating sites, and other sources.

Partners

Network connects hospitals, clinics, and health departments.

Services

Videoconferencing and media services include assistance with getting started in telemedicine, real time support with live videoconferencing and webstreaming, and video-on-demand. UTN guides health care providers in developing patient care applications and new continuing education programs. A schedule of live and on-demand educational programs is available to health professionals for viewing. Clinical telemedicine services include patient exams, patient consultations, and follow-up exams. UTN will assist health care providers to develop new clinical telemedicine services.

Membership and Fees

Rates for videoconferencing services available at: www.utahtelehealth.net/services/Service_Pricelist.pdf

Technology, Equipment, and Vendors

UTN is a hub and spoke model with a redundant core, connects to the University of Utah Hospital, the University of Utah, Internet2, National Lambda Rail, and the Internet via two one Gigabit Ethernet connections. Most network sites utilize dedicated T1(1.544Mbps) WAN services. Some members use DSL. All WAN services support data, voice, and video communications using IP. With a high speed backbone that incorporates Video Bridge technology, UTN can provide simultaneous connection of three or more participants into one or more videoconferences. Equipment includes

cameras, monitors, and codecs as well as room, desktop, PC, and mobile systems. The majority of endpoints use Polycom models, but UTN can support endpoints from major vendors including Tandberg, Lifesize, Radvision and Sony.

Successful Aspects

Focus on continuing to build and expand the network through collaboration with providers.

Key Messages for Maryland

Emphasis on providing technical support to healthcare providers, including assistance in getting started with telemedicine.

VIRGINIA: Virginia Telehealth Network (university-based, non-profit)

<http://ehealthvirginia.org>; <http://www.healthsystem.virginia.edu/pub/office-of-telemedicine/>

Organization Description

Telemedicine efforts in Virginia are led by the Virginia Telehealth Network (VTN) and the University of Virginia's Office of Telemedicine, which have facilitated visits with thousands of patients and providers in 32 different specialties.

Inception and Funding

The UVA Office of Telemedicine launched a comprehensive program in 1994 to provide specialty medical care and distance learning to underserved regions. Awarded a HRSA Telehealth Resource Center Grant to serve as a multi-level telehealth resource center in the Mid-Atlantic region. They will build upon and expand the mentoring and program development services provided by the Office of Telemedicine through the Mid-Atlantic Telehealth Resource Center (MATRC). Using this HRSA funding they will seek to further expand telehealth activities in Virginia, North Carolina, Kentucky, West Virginia, Maryland, Delaware, and the District of Columbia.

Partners

Anthem Blue Cross Blue Shield; MedVirginia; Richmond Orthopedics; Bath County Community Hospital; Edward Via College of Osteopathic Medicine; Inova Health; Medical Society of Virginia; Riverside Health System; UVA Center for Telehealth; UVA at Wise Foundation; Valley Health; GW University School of Nursing; Southeastern Telehealth; Southwest Virginia Community Health System; Virginia Community Healthcare Association; Virginia Council of Nurse Practitioners; Center for Innovative Technology; Old Dominion University; Virginia Department of Medical Assistance Services

Services

Telemedicine consultations, distance learning for health care professionals, transfer of images, ability to share electronic health records, clinical research, health education applications, and outreach projects. Their Rural Health Care Pilot Project is working to develop a Virginia Acute Stroke Telehealth (VAST) network with the intent to produce a viable stroke model that can be implemented statewide. Virginia is requiring their HIE to offer plans for synergy with the state's telemedicine initiatives. The UVA Office of Telemedicine uses surveys and metrics to collect data from patients, practitioners, and partner sites to assess the quality and satisfaction of telemedicine

services. The Office of Telemedicine also mentors fledgling telemedicine programs to develop and expand their networks and services. Telemedicine specialties include: Cardiology, Child & Family Psychiatry, Dermatology, Endocrinology, Gastroenterology, Gynecology, Hepatology, High Risk OB, Infectious Disease, Nephrology, Neurology, Pediatric Cardiology, Pediatric Orthopedics, Psychiatry, Retinopathy, Urology, and Wound Care.

Membership and Fees

The UVA Office of Telemedicine provides guidance to clinics in becoming a UVA Telemedicine Partner Site. Rates of service are estimated based on requested videoconferencing services.

Technology, Equipment, and Vendors

TV screen, camera, and broadband internet technology. Tandberg and Polycom equipment. The vision for VAST is a robust, secure, and sustainable telemedicine network that has sufficient scalable, high capacity-links communicating from the hubs to the cloud. The goal is to support health care applications of the end-to-end networks to allow for seamless and dynamic routing of data.

Successful Aspects

Focus on developing a comprehensive stroke network throughout the state.

Key Messages for Maryland

Effort to integrate the statewide HIE with telemedicine. Expanding telehealth activities to mid-Atlantic states, including Maryland.

WYOMING: Wyoming Telehealth Consortium (consortium)

<http://wyomingtelehealth.org/>

Organization Description

The Wyoming Telehealth Consortium (WTC) aims to facilitate the operation of a statewide interoperable telemedicine/telehealth network using existing internet protocol based communication and videoconferencing infrastructure and telecommunication services.

Inception and Funding

Established in 2009 and given statutory authority by the Wyoming Legislature to coordinate and promote telehealth activities within Wyoming.

Partners

Consortium is comprised of members (e.g. department of health, hospital association, medical centers, medical society, health information organization, university, department of corrections, business council, veterans' administration, Indian health service, telecommunications association, and board of medicine).

Services

Provider registry and informational resources about videoconferencing (e.g. resources to assist providers with setting up and providing telehealth services; resources for hospitals and

practitioners to implement the Centers for Medicare and Medicaid Services final rule on privileging and credentialing requirements; telehealth protocols and procedures for cardiology, pediatrics, and stroke).

Membership and Fees

Information not provided.

Technology, Equipment, and Vendors

Information provided about the Polycom Converged Management Application CMA Desktop System.

Successful Aspects

Consortium serves as an informational resource to help providers in adopting telemedicine.

Key Messages for Maryland

Directory of Wyoming telehealth providers, including name, location, specialty, and phone number available on public site.

ONTARIO, CANADA: Ontario Telemedicine Network (non-profit)

<http://otn.ca/en>

Organization Description

The Ontario Telemedicine Network (OTN) develops and supports telemedicine solutions that enhance access and quality of health care, and inspire adoption by health care providers, organizations, and the public. OTN envisions telemedicine as a mainstream channel for health care delivery and education.

Inception and Funding

OTN is funded by the Government of Ontario.

Partners

Academic health science centers, community hospitals, psychiatric hospitals, family health teams, community health centers, clinics, nursing stations, medical and nursing schools, professional organizations, local health integration networks, first nations communities, long-term care homes, educational facilities, public health.

Services

OTN offers scheduling, video conferencing, a telemedicine directory and site finder, tools and guidelines to develop telemedicine programs, and learning events. Includes programs for mental health and addictions, teledermatology, telestroke, teletrauma, teleburn, telehomecare, teleophthalmology, aboriginal health access, and telemedicine nursing for delivering clinical telemedicine at member sites.

Membership and Fees

All plans include private and secure clinical conferencing, with access to more than 3,000 telemedicine systems. Membership fees vary based on type of organization.

Technology, Equipment, and Vendors

Single point of access for videoconferences from room-based systems or from desktop, laptop and/or mobile devices, using a private and secure Internet connection.

Successful Aspects

Advanced network offering telemedicine services across wide range of specialties.

Key Messages for Maryland

Capability for providers to sign up for an account in the telemedicine registry, including a site profile to advertise, coordinate, and manage their telemedicine services (accessible after log-in).

Appendix H: Md. Code Ann., Insurance § 15-139

Begin quoted text



Md. INSURANCE Code Ann. § 15-139

§ 15-139. Coverage for services delivered through telemedicine

(a) "Telemedicine" defined. --

(1) In this section, "telemedicine" means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located.

(2) "Telemedicine" does not include:

- (i) an audio-only telephone conversation between a health care provider and a patient;
- (ii) an electronic mail message between a health care provider and a patient; or
- (iii) a facsimile transmission between a health care provider and a patient.

(b) Applicability. -- This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) Coverage. -- An entity subject to this section:

(1) shall provide coverage under a health insurance policy or contract for health care services appropriately delivered through telemedicine; and

(2) may not exclude from coverage a health care service solely because it is provided through telemedicine and is not provided through an in-person consultation or contact between a health care provider and a patient.

(d) Reimbursement and deductible. -- An entity subject to this section:

(1) shall reimburse a health care provider for the diagnosis, consultation, and treatment of an insured patient for a health care service covered under a health insurance policy or contract that can be appropriately provided through telemedicine;

(2) is not required to:

(i) reimburse a health care provider for a health care service delivered in person or through telemedicine that is not a covered benefit under the health insurance policy or contract; or

(ii) reimburse a health care provider who is not a covered provider under the health insurance policy or contract; and

(3) (i) may impose a deductible, copayment, or coinsurance amount on benefits for health care services that are delivered either through an in-person consultation or through telemedicine;

(ii) may impose an annual dollar maximum as permitted by federal law; and

(iii) may not impose a lifetime dollar maximum.

(e) Utilization review. -- An entity subject to this section may undertake utilization review, including preauthorization, to determine the appropriateness of any health care service whether the service is delivered through an in-person consultation or through telemedicine if the appropriateness of the health care service is determined in the same manner.

(f) Discrimination prohibited. -- A health insurance policy or contract may not distinguish between patients in rural or urban locations in providing coverage under the policy or contract for health care services delivered through telemedicine.

(g) Adverse decision. -- A decision by an entity subject to this section not to provide coverage for telemedicine in accordance with this section constitutes an adverse decision, as defined in § 15-10A-01 of this title, if the decision is based on a finding that telemedicine is not medically necessary, appropriate, or efficient.

HISTORY: 2012, chs. 579, 580; 2013, ch. 280.

NOTES: EDITOR'S NOTE. --Section 4, chs. 579 and 580, Acts 2012, provides that "this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2012."

Section 5, chs. 579 and 580, Acts 2012, provides that the acts shall take effect October 1, 2012.
EFFECT OF AMENDMENTS. --Chapter 280, Acts 2013, effective October 1, 2013, reenacted (a) without change.

End quoted text

Appendix I: Md. Code Ann., Health - General §19-319

Begin quoted text



Md. HEALTH-GENERAL Code Ann. § 19-319

§ 19-319. Qualifications for licenses

(a) In general. -- To qualify for a license, an applicant and the hospital or related institution to be operated shall meet the requirements of this section.

(b) Applicant. -- An applicant who is an individual, and any individual who is applying on behalf of a corporation, association, or government agency shall be:

- (1) At least 18 years old; and
- (2) Of reputable and responsible character.

(c) Hospital, residential treatment center, or related institution. --

(1) The applicant shall have a certificate of need, as required under Subtitle 1 of this title, for the hospital, residential treatment center, or related institution to be operated.

(2) The hospital, residential treatment center, or related institution to be operated shall meet the requirements that the Secretary adopts under this subtitle and Subtitle 12 of this title.

(d) Utilization review program. --

(1) As a condition of licensure, each hospital shall establish a utilization review program for all patients admitted to the hospital. The utilization review program:

- (i) May be conducted by an independent, nonhospital-affiliated review agent;
- (ii) Shall be performed by registered nurses, medical records technicians, or similar qualified personnel supported and supervised by physicians as may be required;
- (iii) Shall be certified by the Secretary if the program meets the minimum standards established under paragraph (4) of this subsection; and
- (iv) Shall be recertified by the Secretary if the hospital makes any changes to the program after the initial certification.

(2) Any change made to a certified utilization review program shall be reported to the Secretary by the hospital within 30 days of the date the change was made.

(3) If a hospital fails to provide the utilization review program required under this subsection, the Secretary may impose the following penalties:

- (i) Delicensure of hospital; or
- (ii) \$ 500 per day for each day the violation continues.

(4) The Secretary shall, by regulation and in consultation with health care providers and payors, establish minimum standards for a utilization review program, directed at appropriateness and quality of inpatient care, as enumerated in the following items:

- (i) Preadmission review of elective admissions;
- (ii) Postadmission review of emergency admissions;
- (iii) Concurrent or retrospective review of all admissions as appropriate;
- (iv) Preauthorization of certain selected procedures if proposed to be performed on an inpatient basis;
- (v) Continued stay review based on recognized objective criteria;
- (vi) Discharge planning review; and
- (vii) Readmission review.

(5) A patient may not be charged for any days disallowed as a result of retrospective review under paragraph (4) of this subsection unless the patient refuses to leave the hospital when it is medically appropriate to do so and the disallowed days occur:

- (i) After the hospital has notified the patient in writing of the potential disallowance; or
- (ii) As a direct result of the noncompliance by the patient to treatment or hospital regulations.

(6) A hospital shall be exempt from requiring a utilization review program for a patient if:

- (i) 1. The patient is insured by a third-party payor; and
2. The third-party payor has a utilization review program for its subscribers or beneficiaries which meets the minimum standards as adopted in paragraph (4) of this subsection; or
- (ii) The patient is a subscriber or member of a health maintenance organization as defined in § 19-701 of this title.

(7) Where federal regulations or guidelines for a federally mandated utilization review program for federally insured patients differ from standards established under paragraph (4) of this subsection, the Secretary may waive a specific standard if the program achieves the same objectives as the standards established by the Secretary.

(8) The Secretary may establish record keeping and reporting requirements:

- (i) To evaluate the effectiveness of hospitals' utilization review programs; and
- (ii) To determine if the utilization review programs are in compliance with the provisions of this section and regulations adopted by the Secretary to administer this section.

(e) Definitions. --

- (1) (i) In this subsection the following words have the meanings indicated.

(ii) 1. "Telemedicine" means the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient.

2. "Telemedicine" does not include:

- A. An audio-only telephone conversation between a physician and a patient;
- B. An electronic mail message between a physician and a patient; or
- C. A facsimile transmission between a physician and a patient.

(iii) "Uniform standard credentialing form" means:

1. The form designated by the Secretary through regulation for credentialing physicians who seek to be employed by or have staff privileges at a hospital; or

2. The uniform credentialing form that the Insurance Commissioner designates under § 15-112.1 of the Insurance Article.

(2) As a condition of licensure, each hospital shall:

(i) Establish a credentialing process for the physicians who are employed by or who have staff privileges at the hospital; and

(ii) Use the uniform standard credentialing form as the initial application of a physician seeking to be credentialed.

(3) Use of the uniform standard credentialing form does not preclude a hospital from requiring supplemental or additional information as part of the hospital's credentialing process.

(4) The Secretary shall, by regulation and in consultation with hospitals, physicians, interested community and advocacy groups, and representatives of the Maryland Defense Bar and Plaintiffs' Bar, establish minimum standards for a credentialing process which shall include:

(i) A formal written appointment process documenting the physician's education, clinical expertise, licensure history, insurance history, medical history, claims history, and professional experience.

(ii) A requirement that an initial appointment to staff not be complete until the physician has successfully completed a probationary period.

(iii) A formal, written reappointment process to be conducted at least every 2 years. The reappointment process shall document the physician's pattern of performance by analyzing:

- 1. Claims filed against the physician;
- 2. Data dealing with utilization, quality, and risk;
- 3. Clinical skills;
- 4. Adherence to hospital bylaws, policies, and procedures;
- 5. Compliance with continuing education requirements;
- 6. Mental and physical status; and

7. The results of the practitioner performance evaluation process under subsection (i) of this section.

(5) If requested by the Department, a hospital shall provide documentation that, prior to employing or granting privileges to a physician, the hospital has complied with the requirements of this subsection and that, prior to renewing employment or privileges, the hospital has complied with the requirements of this subsection.

(6) Notwithstanding any other provision of this subsection, in its credentialing and privileging process for a physician who provides medical services to patients at the hospital only through telemedicine from a distant-site hospital or distant-site telemedicine entity, a hospital may rely on the credentialing and privileging decisions made for the physician by the distant-site hospital or distant-site telemedicine entity, as authorized under 42 C.F.R. Part 482, if:

(i) The physician who provides medical services through telemedicine holds a license to practice medicine in the State issued under Title 14 of the Health Occupations Article; and

(ii) The credentialing and privileging decisions with respect to the physician who provides medical services through telemedicine are:

1. Approved by the medical staff of the hospital; and

2. Recommended by the medical staff of the hospital to the hospital's governing body.

(7) If a hospital fails to establish or maintain a credentialing process required under this subsection, the Secretary may impose the following penalties:

(i) Delicensure of the hospital; or

(ii) \$ 500 per day for each day the violation continues.

(f) Procurement of organs and tissues. -- As a condition of licensure, each accredited and nonaccredited hospital shall develop a protocol for the procurement of organs and tissues.

(g) Risk management program. --

(1) As a condition of licensure, each hospital shall establish a risk management program.

(2) The Secretary shall, by regulation and in consultation with hospitals, physicians, interested community and advocacy groups, and representatives of the Maryland Defense Bar and Plaintiffs' Bar establish minimum standards for a risk management program which shall include:

(i) A board policy statement indicating commitment to the risk management program;

(ii) A requirement that one person be assigned the responsibility for coordinating the program;

(iii) An internal staff committee structure to conduct ongoing review and evaluation of risk management activities;

(iv) A formal written program for addressing patient complaints;

(v) A documented facility-wide risk reporting system;

(vi) Ongoing risk management education programs for all staff; and

(vii) Documentation that the risk management and quality assurance programs share relevant information.

(3) If a hospital fails to establish or maintain a risk management program required under this subsection, the Secretary may impose the following penalties:

(i) Delicensure of the hospital; or

(ii) \$ 500 per day for each day the violation continues.

(h) Compliance with and notice explaining Centers for Disease Control and Prevention's guidelines on universal precautions. --

(1) As a condition of licensure, each hospital and related institution shall:

(i) Adopt, implement, and enforce a policy that requires, except in an emergency life-threatening situation where it is not feasible or practicable, all employees and medical staff involved in patient care services to comply with the Centers for Disease Control and Prevention guidelines on universal precautions; and

(ii) Display the notice developed under *§ 1-207 of the Health Occupations Article* at the entrance to the hospital or related institution.

(2) If a hospital or related institution fails to comply with the requirements of this subsection, the Secretary may impose a fine of up to \$ 500 per day per violation for each day a violation continues.

(i) Practitioner performance evaluation process. --

(1) As a condition of licensure, each hospital shall establish a practitioner performance evaluation process that objectively evaluates the performance of each member of the medical staff at the hospital.

(2) The practitioner performance evaluation process shall include a review of care provided to patients at the hospital by the members of the medical staff.

(3) The review of care shall:

(i) Be undertaken for cases chosen at random and for cases with unexpected adverse outcomes;

(ii) Be based on objective review standards;

(iii) Include a review of the appropriateness of the plan of care for the patient, particularly any medical procedures performed on the patient, in relation to the patient's condition; and

(iv) Be conducted by members of the medical staff or, at the discretion of the hospital, external reviewers, who:

1. Are of the same specialty as the member of the medical staff under review;
2. Have been trained to perform practitioner performance evaluation; and
3. Are not otherwise associated with the case under review.

(4) A hospital shall take into account the results of the practitioner performance evaluation process for a member of the medical staff in the reappointment process established under subsection (e) of this section.

(5) If a hospital fails to comply with the requirements of this subsection, the Secretary may impose a fine of up to \$ 500 per day per violation for each day a violation continues.

HISTORY: An. Code 1957, art. 43, §§ 559, 560; 1982, ch. 21, § 2; ch. 107, § 1; 1985, ch. 111; 1986, ch. 5, § 1; ch. 642, § 3; chs. 673, 690, 733; 1990, ch. 671; 1992, ch. 154, § 1; ch. 581; 1993, ch. 99; 1997, ch. 130; 2002, ch. 189; 2003, ch. 21, § 1; 2004, ch. 25, §§ 1, 6; 2006, ch. 232; 2009, chs. 90, 91; 2011, ch. 587; 2013, ch. 324.

NOTES: EFFECT OF AMENDMENTS. --Chapters 90 and 91, Acts 2009, effective October 1, 2009, made identical changes. Each added (e)(1)(ii), redesignated accordingly and made related changes

Chapter 587, Acts 2011, effective October 1, 2011, reenacted (a) without change; rewrote (e)(4)(iii) without substantive change; and added (i).

Chapter 324, Acts 2013, effective October 1, 2013, rewrote (e)(1) and added (e)(6) and redesignated accordingly.

End quoted text

Appendix J: Md. Code Ann., Health - General § 15-105.2

Begin quoted text



Md. HEALTH-GENERAL Code Ann. § 15-105.2

§ 15-105.2. Reimbursement to health care providers

(a) In general. -- The Program shall reimburse health care providers in accordance with the requirements of Title 19, Subtitle 1, Part IV of this article.

(b) Telemedicine reimbursements. --

(1) Subject to paragraph (2) of this subsection and unless otherwise specifically prohibited or limited by federal or State law, the Program shall reimburse a health care provider for a health care service delivered by telemedicine, as defined in § 15-139 of the Insurance Article, in the same manner as the same health care service is reimbursed when delivered in person.

(2) Reimbursement under paragraph (1) of this subsection is required only for a health care service that:

(i) Is medically necessary; and

(ii) Is provided:

1. For the treatment of cardiovascular disease or stroke;
2. In an emergency department setting; and
3. When an appropriate specialist is not available.

(3) The Department shall adopt regulations to carry out this subsection.

HISTORY: 2009, ch. 689; 2013, ch. 280.

NOTES: EFFECT OF AMENDMENTS. --Chapter 280, Acts 2013, effective October 1, 2013, added the (a) designation and added (b).

End quoted text

Appendix K: Proposed Maryland Credentialing Regulations, COMAR 10.07.01, .09, .24, and .29

Title 10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 07 HOSPITALS

10.07.01 Acute General Hospitals and Special Hospitals

Authority: Health-General Article, §§19.308, 19-319 and 19-349.1, Annotated Code of Maryland

10.07.01 (October 4, 2013)

.01 Definitions.

A. (text unchanged)

B. Terms Defined.

(1)—(26) (text unchanged)

(26-1) *Telemedicine.*

(a) *“Telemedicine” means the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient.*

(b) *“Telemedicine” does not include:*

(i) *An audio only telephone conversation between the physician and patient;*

(ii) *An electronic mail message between a physician and a patient; or*

(iii) *A facsimile transmission between a physician and a patient.*

(27) (text unchanged)

(27-1) *“Uniform standard credentialing form” means:*

(a) *The form designated by the Department through COMAR 10.07.01.24C(6) for credentialing physicians who seek to be employed by or have staff privileges at a hospital; or*

(b) *The uniform credentialing form that the Insurance Commissioner designates under Insurance Article, §15–112.1, Annotated Code of Maryland.*

(28)—(29) (text unchanged)

.09 Service Standards — Non-Accredited Hospitals.

A. Acute General Hospitals and Special Hospitals. The 2013 Hospital Accreditation Standards ([2009 Edition] *July Update*, The Joint Commission, One Renaissance Blvd., Oakbrook, Illinois 60181), is incorporated by reference [], with the following exception for the reason indicated: Chapter Life Safety (LS) pages 129—164 do not apply for hospitals that are not participating providers in the Medicare program as these standards are outside of the Department's jurisdiction].

B. (text unchanged)

.24 Physician Credentialing Process.

A. General. [On or before January 1, 1988, in] *In* accordance with this regulation, a hospital shall have in effect a credentialing process.

B. (text unchanged)

C. Specific Standard—Appointment and Employment Process.

(1)—(5) (text unchanged)

(6) Uniform Standard Credentialing Form.

(a) [Effective January 1, 2004, a] A hospital shall use the uniform standard credentialing form approved by the Department for the initial credentialing of a physician seeking appointment or employment.

(b)—(c) (text unchanged)

D.—G. (text unchanged)

H. Telemedicine. Notwithstanding any other provision of COMAR 10.07.01.24, in its credentialing and privileging process for a physician who provides medical services to the patients at the hospital only through telemedicine from a distant-site hospital or distant-site telemedicine entity, a hospital may rely on the credentialing and privileging decisions made for the physician by the distant-site hospital or distant-site telemedicine entity as authorized under 42 C.F.R. Part 482, if:

(1) The physician who provides medical services through telemedicine holds a license to practice medicine in the State under Health Occupations Article, Title 14, Annotated Code of Maryland; and

(2) The credentialing and privileging decisions with respect to the physician who provides medical services through telemedicine are:

(a) Approved by the medical staff of the hospital; and

(b) Recommended by the medical staff of the hospital to the hospital's governing body.

[H.] I.—[I.] J. (text unchanged)

.29 Notice to Patients of Outpatient on Observation Status.

A. A hospital shall provide both an oral and written notice to a patient of:

(1) The patient's outpatient on observation status;

(2) The billing implications of the outpatient on observation status; and

(3) The impact of the outpatient on observation status on the patient's eligibility for Medicare rehabilitation services if:

(a) The patient received on-site services from the hospital for more than 23 consecutive hours;

(b) The on-site services received by the patient include a hospital bed and meals that have been provided in an area of the hospital other than the Emergency Department; and

(c) The patient is classified as an outpatient at the hospital for observation rather than as an admitted inpatient.

B. The written notice shall include:

(1) That the patient is considered to be on observation as an outpatient and is not admitted as an inpatient;

(2) The reason or rationale that the patient has not been admitted for inpatient services;

(3) That the patient, if needed upon discharge, may not qualify for Medicare reimbursement for sub-acute rehabilitation care; and

(4) That there may be billing implications based on their outpatient status:

(5) The name and title of the staff who provided the oral notice stating the date and time of the oral notice; and

(6) The signature of the patient to verify an understanding and receipt of the written notice.

C. The written notice shall be provided not later than 23 hours after the patient has been determined to require observation as an outpatient.

D. The oral and written notice shall be provided in a manner that is understood by the patient.

E. If the patient lacks capacity to understand the medical or financial implications of his or her outpatient on observation status, the oral and written notice shall be provided to a person authorized to make medical or financial decisions for the patient, including:

(1) A guardian of the person under Estates and Trusts Article, §13-705, Annotated Code of Maryland;

(2) A guardian of the property under Estates and Trusts Article, §13-201, Annotated Code of Maryland;

(3) An agent appointed under an advance directive that meets the requirements of Health-General Article, §5-602, Annotated Code of Maryland;

(4) A surrogate decision maker with authority under Health-General Article, §5-605, Annotated Code of Maryland;

(5) An agent appointed under a power of attorney that meets the requirements of Estates and Trusts Article, Title 17, Annotated Code of Maryland;

(6) A representative payee or other similar fiduciary; or

(7) Any other person, if that person was designated by the patient who was competent at the time of designation, and the patient or representative has provided the hospital with documentation of the designation.

JOSHUA M. SHARFSTEIN, M.D.

Secretary of Health and Mental Hygiene

Appendix L: Maryland Medicaid Telemedicine Regulations COMAR 10.09.49

Begin quoted text

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 09 MEDICAL CARE PROGRAMS

Chapter 49 Telemedicine Services

Authority: Health-General Article, §2-104(b), Annotated Code of Maryland; Ch. 280, Acts of 2013

.01 Scope.

A. This chapter applies to two telemedicine programs — the Rural Access Telemedicine Program and the Cardiovascular Disease and Stroke Telemedicine Program.

B. The purpose of providing medically necessary services via telemedicine is to improve:

- (1) Access to outpatient specialty care, thus reducing preventable hospitalizations and reducing barriers to health care access;
- (2) Patient compliance with treatment plans;
- (3) Health outcomes through timely disease detection and treatment options; and
- (4) Capacity and choice for outpatient ongoing treatment in underserved areas of the State.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) “Consulting provider” means the licensed provider at the distant site who provides medically necessary consultation services to the patient at the originating site via telemedicine upon request from the originating site provider.

(2) “Department” means the Department of Health and Mental Hygiene, which is the single State agency designated to administer the telemedicine program.

(3) "Designated rural geographic areas" means:

- (a) Allegany County;
- (b) Calvert County;
- (c) Caroline County;
- (d) Cecil County;
- (e) Charles County;
- (f) Dorchester County;
- (g) Garrett County;

- (h) Kent County;
- (i) Queen Anne's County;
- (j) Somerset County;
- (k) St. Mary's County;
- (l) Talbot County;
- (m) Washington County;
- (n) Wicomico County; and
- (o) Worcester County.

(4) "Distant site" means a site approved by the Department to provide telemedicine services, at which the licensed consulting provider is located at the time the service is provided via technology-assisted communication.

(5) "Federally qualified health center (FQHC)" has the meaning stated in Health-General Article, §24-1301, Annotated Code of Maryland.

(6) "Medically necessary" means that the service or benefit is:

- (a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
- (b) Consistent with currently accepted standards of good medical practice;
- (c) The most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and
- (d) Not primarily for the convenience of the consumer, family, or provider.

(7) "Originating site" means the location of an eligible Medicaid participant at the time the service being furnished via technology-assisted communication occurs, which is a site approved by the Department to provide telemedicine services and which:

- (a) For the Rural Access Telemedicine Program, is located within a designated rural geographic area, in which an eligible participant is located at the time the telemedicine service is delivered; or
- (b) For the Cardiovascular Disease and Stroke Telemedicine Program, is located in an emergency room when an appropriate specialist is not available.

(8) "Originating site facility fee" means the amount the Department reimburses an approved originating site for the telemedicine transmission.

(9) "Professional fee" means the Departmental fee schedule for clinical services which is incorporated by reference in COMAR 10.09.07.02.

(10) "Provider" means:

- (a) An individual, association, partnership, corporation, unincorporated group, or any other person authorized, licensed, or certified to provide services for Medical Assistance participants and

who, through appropriate agreement with the Department, has been identified as a Maryland Medical Assistance Provider by the issuance of an individual account number;

(b) An agent, employee, or related party of a person identified in §B(10)(a) of this regulation; or

(c) An individual or any other person with an ownership interest in a person identified in §B(10)(a) of this regulation.

(11) "Security" means the protection of information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction.

(12) "Store and Forward technology" means the transmission of medical images or other media captured by the originating site provider and sent electronically to a distant site provider, who does not physically interact with the patient located at the originating site.

(13) "Technology-assisted communication" means multimedia communication equipment permitting two-way real-time interactive communication between a patient at an originating site and a consulting provider at a distant site.

(14) "Telemedicine" means the delivery of medically necessary services to a patient at an originating site by a consulting provider, through the use of technology-assisted communication.

.03 Approval.

The Department shall grant approval to originating and consulting providers to receive State and federal funds for providing telemedicine services if the telemedicine provider meets the requirements of this chapter.

.04 Service Model.

A. Telemedicine improves access to consulting providers from other areas of the State, the District of Columbia, or a contiguous state.

B. Telemedicine providers may be part of a private practice, hospital, or other health care system.

C. Medical Assistance-approved originating site providers shall engage in agreements with consulting providers for telemedicine services.

D. Fee-for-service reimbursement for professional services shall be in accordance with the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, which is incorporated by reference in COMAR 10.09.07.02.

.05 Covered Services.

A. Rural Access Telemedicine Program.

(1) Through the Rural Access Telemedicine Program, approved providers located in designated rural geographic areas may provide medically necessary services to Medical Assistance participants through technology-assisted communication.

(2) Under the Rural Access Telemedicine Program, the Department shall cover:

(a) Medically necessary services covered by the Maryland Medical Assistance Program rendered by an originating site provider that are distinct from the telemedicine services provided by a consulting provider;

(b) Medically necessary consultation services covered by the Maryland Medical Assistance Program rendered by an approved consulting provider that can be delivered using technology-assisted communication; and

(c) An approved originating site for the originating site facility fee.

B. Cardiovascular Disease and Stroke Telemedicine Program.

(1) Through the Cardiovascular Disease and Stroke Telemedicine Program, approved providers may render services to Medical Assistance participants in emergency departments where no specialist is available to provide timely consultation and diagnostic evaluation for cardiovascular disease or stroke care.

(2) Under the Cardiovascular Disease and Stroke Telemedicine Program, the Department shall cover:

(a) Medically necessary services covered by the Maryland Medical Assistance Program rendered by an approved originating site provider in a hospital emergency department setting for the treatment of cardiovascular disease or stroke that are distinct from the telemedicine services provided by a consulting provider;

(b) The professional fee for an approved consulting provider for initial telemedicine consultation for services furnished before, during, and after communicating with the Medical Assistance participant presenting in a hospital emergency department setting with cardiovascular disease or stroke if:

(i) The consulting provider is not the physician of record or the attending physician; and

(ii) The initial telemedicine consultation is distinct from the care provided by the physician of record or the attending physician; and

(c) An approved originating site for the originating site facility fee for telemedicine services provided to a Medical Assistance participant for the treatment of cardiovascular disease or stroke if the telemedicine services rendered are:

(i) Medically necessary;

(ii) Provided in a hospital emergency department setting in the State; and

(iii) Provided when there are no specialists available at the originating site to provide a consultation and review diagnostic tests integral to the consultation in a timely manner.

.06 Participant Eligibility.

A participant is eligible to receive telemedicine services if the individual:

A. Is enrolled in the Maryland Medical Assistance Program;

B. For the Rural Access Telemedicine Program, consents to telemedicine services unless there is an emergency that prevents obtaining consent, which the originating site shall document in the participant's medical record; and

C. Is present at the originating site at the time the telemedicine service is rendered.

.07 Provider Conditions for Participation.

A. To participate in the Program, the provider shall:

(1) Be enrolled as Medical Assistance Program provider;

(2) Meet the requirements for participation in the Maryland Medical Assistance Program as set forth in:

(a) COMAR 10.09.36.02;

(b) COMAR 10.09.36.03; and

(c) The COMAR chapter defining the covered service being rendered;

(3) Apply for participation in the Program using the application form designated by the Department;

(4) Be approved for participation by the Department; and

(5) Have a written contingency plan when telemedicine is unavailable.

B. Rural Access Telemedicine Program Approved Originating Site. The following sites may be approved as an originating site for Rural Access Telemedicine Program service delivery:

(1) A FQHC;

(2) A hospital, including the emergency department;

(3) The office of a physician, nurse practitioner, or nurse midwife;

(4) A renal dialysis center;

(5) A local health department; and

(6) A nursing facility.

C. Rural Access Telemedicine Program Approved Distant Site. The following provider types who practice within the State, the District of Columbia, or a contiguous state may be approved as consulting providers for Rural Access Telemedicine Program consultation services:

(1) A physician;

(2) A nurse practitioner; and

(3) A nurse midwife.

D. Cardiovascular Disease and Stroke Telemedicine Program Approved Originating Site. A Maryland hospital may be approved as an originating site for the Cardiovascular Disease and Stroke Telemedicine Program if no specialist is available to provide timely consultation and diagnostic evaluation for cardiovascular disease or stroke care.

E. Cardiovascular Disease and Stroke Telemedicine Program Approved Distant Site. Consulting specialty providers who practice within the State, the District of Columbia, or a contiguous state may be approved as consulting providers for Cardiovascular Disease and Stroke Telemedicine Program consultation services

.08 Technical Requirements.

A. A provider of health care services delivered through telemedicine shall adopt and implement technology in a manner that supports the standard of care to deliver the required service.

B. The technology shall be accredited or certified by a Department-recognized national organization.

C. A provider of health services delivered through telemedicine shall have, at a minimum, video technology components as follows:

(1) A camera that has the ability to manually or under remote control provide multiple views of a patient with the capability of altering the resolution, focus, and zoom requirements according to the consultation;

(2) Audio equipment that ensures clear communication and includes echo cancellation;

(3) Bandwidth speeds and resolution of video calls that is not less than 384kbt/s;

(4) Supports a frame rate of 15 frames per second where motion is assessed;

(5) Maintains video consultation for both sending the images and downloading at less than 300 milliseconds;

(6) Supports high definition video resolution; and

(7) Selects display monitor size depending on the hardware and software that is used in the telemedicine service.

.09 Confidentiality.

The originating and consulting providers:

A. Shall comply with the laws and regulations concerning the privacy and security of protected health information under:

(1) Health-General Article, Title 4, Subtitle 3, Annotated Code of Maryland; and

(2) The Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. §§1320d et seq., as amended, the HITECH Act, 42 U.S.C. §§17932, et seq., as amended, and 45 CFR Parts 160 and 164, as amended;

B. Shall ensure that all interactive video technology-assisted communication comply with HIPAA patient privacy and security regulations at the originating site, at the distance site, and in the transmission process;

C. May not disseminate any participant images or information to other entities without the participant's consent, unless there is an emergency that prevents obtaining consent; and

D. May not store at originating and distant sites the video images or audio portion of the telemedicine service for future use.

.10 Medical Records.

A. The originating and consulting providers shall maintain documentation in the same manner as during an in-person visit or consultation, using either electronic or paper medical records.

B. Telemedicine records shall be retained according to the provisions of Health-General Article, §4-403, Annotated Code of Maryland.

C. The participant has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.

.11 Limitations.

A. A service provided through telemedicine is subject to the same program restrictions, preauthorizations, limitations, and coverage that exist for the service when provided other than through telemedicine.

B. A telemedicine service does not include:

- (1) An audio-only telephone conversation between a health care provider and a patient;
- (2) An electronic mail message between a health care provider and a patient;
- (3) A facsimile transmission between a health care provider and a patient; or
- (4) A telephone conversation, electronic mail message, or facsimile transmission between the originating and consulting providers without interaction between the consulting provider and the patient.

C. "Store and Forward" technology does not meet the Maryland Medical Assistance Program's definition of telemedicine.

D. Telemedicine-delivered services may not bill to the Maryland Medical Assistance Program when technical difficulties preclude the delivery of part or all of the telemedicine session.

E. The Department may not reimburse for consultation that occurs during an ambulance transport.

F. Telemental health services are not covered under this regulation but are covered under COMAR 10.21.30.

G. The Department may not reimburse for services that require in-person evaluation or that cannot be reasonably delivered via telemedicine.

H. The Department may not reimburse consulting providers for a facility fee.

.12 Reimbursement.

A. There are two categories of fees that the Department shall reimburse an approved telemedicine provider, as applicable:

- (1) Originating site facility fee; and

(2) Professional fee.

B. Originating Site Facility Fee.

(1) The originating site facility fee is set:

(a) In the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, which is incorporated by reference in COMAR 10.09.07.02; or

(b) By the Health Services Cost Review Commission for sites located in regulated space.

(2) Originating sites shall use the appropriate telemedicine service modifier.

(3) Fees paid to the originating site may be used to pay for:

(a) Line or per minute usage charges, or both; and

(b) Any additional programmatic, administrative, clinical, or contingency support at the originating site.

C. Professional Fee.

(1) The professional fee for originating and consulting providers is set forth in the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, which is incorporated by reference in COMAR 10.09.02.07.

(2) Professional fees charged for telemedicine services shall be billed with the appropriate telemedicine service modifier.

Administrative History

Effective date: September 30, 2013 (40:19 Md. R. 1546)

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Appendix M: MHCC Telemedicine Information Brief

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Introduction

The Maryland Health Care Commission (MHCC or Commission) conducted an environmental scan (scan) to assess the Maryland telemedicine landscape to inform the Telemedicine Task Force (task force). The last meetings of the task force were held in 2011, and the telemedicine landscape has since changed as telemedicine adoption has increased. The scan included a literature review of the financial impacts of telemedicine, an overview of telemedicine initiatives among office-based physicians as well as acute care hospitals, and a review of various telemedicine products. Telemedicine, as defined in Maryland law, means the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient.

Telemedicine Task Force

Maryland has been working to expand the use of telemedicine in the State to improve access to care and generate cost savings. Senate Bill 776, *Telemedicine Task Force – Maryland Health Care Commission* (SB 776), signed into law by Governor Martin O'Malley in May 2013, requires the MHCC, in conjunction with the Maryland Health Quality and Cost Council, to reconvene the task force, which met originally in 2010 and last met in 2011.⁵² The 2011 task force developed *Telemedicine Recommendations*, a report to the Maryland Health Quality and Cost Council that was sent to the State Legislature.⁵³ The recommendations resulted in two laws. Senate Bill 781, *Health Insurance – Coverage for Services Delivered through Telemedicine*, was signed into law in May 2012 by Governor Martin O'Malley, requiring State-regulated payers to provide coverage for health care services delivered through telemedicine.⁵⁴ Senate Bill 798, *Hospitals – Credentialing and Privileging Process – Telemedicine*, signed into law by Governor Martin O'Malley in May 2013, enables a hospital to rely on the credentialing and privileging decisions made of the physician by the distant-site hospital.⁵⁵

The 2013 task force will identify opportunities to further expand the use of telemedicine to improve health status and care delivery in the State, to assess factors related to telehealth, and to identify strategies and solutions for telehealth deployment. The task force's three advisory groups, clinical, finance and business model, and technology solutions and standards, will develop legislative recommendations that identify the role of telemedicine in innovative care delivery models to support the Triple Aim: to improve the health of the population served, to improve the experience of each individual, and to improve affordability as measured by the total cost of care. The task force will assess methods to use telemedicine to increase access to health care, improve

⁵¹ MHCC, *Telemedicine Information Brief*, July 2013. Available at:

http://mhcc.dhmf.maryland.gov/hit/telemedicine/Documents/telemedicine_updates_brief.pdf.

⁵² *Telemedicine Task Force – Maryland Health Care Commission*, SB 776, 2013 Regular Session.

⁵³ MHCC, *Telemedicine Recommendations: A report prepared for the Maryland Health Quality and Cost Council* (December 2011). Available at: http://mhcc.dhmf.maryland.gov/hit/telemedicine/Pages/telemedicine_main.aspx.

⁵⁴ *Health Insurance – Coverage for Services Delivered through Telemedicine*, SB 781, 2012 Regular Session.

⁵⁵ *Hospitals – Credentialing and Privileging Process – Telemedicine*, Senate Bill 798, 2013 Regular Session.

patient outcomes in the State, and identify ways for health care providers to utilize telemedicine as a means to reduce health care costs. An interim report is due to the Governor, Senate Finance Committee and the House Health and Government Operations Committee by January 1, 2014, and a final report is due by December 1, 2014.

Literature Review

The MHCC conducted a literature review assessing the financial impacts of the practice of telemedicine and evaluating telemedicine practiced in an office-based or ambulatory setting. The literature review included sources published since 2011, when the Commission last conducted a literature review of telemedicine for the 2011 *Telemedicine Recommendations* report to the Maryland Health Quality and Cost Council.⁵⁶ The impact of telemedicine on overall health care cost is a key issue to consider in the expansion of telemedicine. Comparable to the implementation of other types of technology in the health care industry, the studies reviewed suggest that office-based telemedicine in certain use cases has demonstrably reduced cost.⁵⁷

The literature review also found evidence that clinical outcomes for office-based telemedicine appear to be comparable to in-person services.^{58, 59, 60} One study found an increase in utilization of specialty services during a period of treatment via telemedicine for mental health needs. It is important to note that an increase in utilization of health care services through telemedicine may not necessarily increase overall cost to the health care system, largely due to the low cost of delivering services through telemedicine.⁶¹ The literature review also found the most widely adopted and studied use case for office-based telemedicine appears to be behavioral health.⁶² Regarding legal liability, there has been limited telemedicine case law, and telemedicine within the legal concept of the standard of care continues to be clarified.⁶³ In general, the research on telemedicine is expanding rapidly; the results of these studies are increasingly being used by policy makers in expanding the use of telemedicine.⁶⁴

⁵⁶ MHCC, *Telemedicine Recommendations: A report prepared for the Maryland Health Quality and Cost Council* (December 2011). Available at: http://mhcc.dhmh.maryland.gov/hit/telemedicine/Pages/telemedicine_main.aspx.

⁵⁷ Mistry, Hema, *Systematic Review of Studies of the Cost-Effectiveness of Telemedicine and Telecare. Changes in the Economic Evidence over 20 Years*. Journal of Telemedicine & Telecare (January 2012).

⁵⁸ Davis, Ann McGrath et. al. *Treating Rural Pediatric Obesity through Telemedicine: Outcomes from a Small Randomized Controlled Trial*. Journal of Pediatric Psychology (February 2013).

⁵⁹ Dorsey, E. Ray et. al. *Randomized Controlled Clinical Trial of 'Virtual House Calls' for Parkinson Disease*. Journal of the American Medical Association Neurology (March 2013).

⁶⁰ Fortney, John et. al. *Practice-Based Versus Telemedicine-Based Collaborative Care for Depression in Rural Federally Qualified Health Centers: A Pragmatic Randomized Comparative Effectiveness Trial*. American Journal of Psychiatry (April 2013).

⁶¹ Fortney, John et. al. *A Budget Impact Analysis of Telemedicine-based Collaborative Care for Depression*. Medical Care (September 2011).

⁶² Mistry, Hema, *Systematic Review of Studies of the Cost-Effectiveness of Telemedicine and Telecare. Changes in the Economic Evidence over 20 Years*. Journal of Telemedicine & Telecare (January 2012); Fortney, John et. al. *Practice-Based Versus Telemedicine-Based Collaborative Care for Depression in Rural Federally Qualified Health Centers: A Pragmatic Randomized Comparative Effectiveness Trial*. American Journal of Psychiatry (April 2013).

⁶³ Gupta, Amar et. al. *Chapter 20: Legal and Regulatory Barriers to Telemedicine in the United States: Public and Private Approaches toward Health Care Reform*. The Globalization of Health Care: Legal and Ethical Issues (I.Glenn Cohen ed., Oxford University Press, forthcoming 2013).

⁶⁴ Wootton, Richard. *Twenty Years of Telemedicine in Chronic Disease Management – An Evidence Synthesis*. Journal of Telemedicine & Telecare (March 2012).

Telemedicine Landscape

Nationally

The American Telemedicine Association (ATA) estimates that there are roughly 200 existing telemedicine networks in the U.S., providing connectivity to over 3,500 sites; further, according to the ATA, half of hospitals nationwide also utilize some form of telemedicine to provide remote services for their patients.⁶⁵ A recent report indicates that nearly 1.3 million U.S. residents will be using telemedicine services by 2017, a nearly sixfold increase since 2012.⁶⁶ The majority of patients receive services via telemedicine that relate to care from a prior hospital admission. As the health care industry aims to reduce hospital readmission rates and track disease progression, telemedicine is expected to reach roughly 1.8 million patients worldwide by 2017.⁶⁷ A key barrier to telemedicine adoption in the U.S. has been the absence of widespread State-regulated payer (payer) reimbursement for services delivered through telemedicine. To date, about 19 states have laws that require payers to compensate for telemedicine care just as they would for traditional face-to-face consultation. Roughly 44 states have some method of telemedicine reimbursement in place for Medicaid.

Maryland Hospitals

As of 2012, approximately 46 percent of hospitals in Maryland reported using telemedicine.⁶⁸ Maryland hospitals using telemedicine to deliver health care services mostly use telemedicine for imaging and consultation. The table below outlines the services that hospitals use to deliver telemedicine.⁶⁹

Hospital	Imaging	Diagnostic	Monitoring	Emergency	Consultation
Anne Arundel Medical Center	✓	✓			✓
Atlantic General Hospital					✓
Baltimore Washington Medical Center	✓				
Bon Secours Baltimore Health System		✓	✓		✓
Calvert Memorial Hospital	✓	✓	✓	✓	✓
Carroll Hospital Center			✓		
Doctors Community Hospital	✓				
Frederick Memorial Hospital	✓	✓	✓	✓	✓
Holy Cross Hospital	✓	✓		✓	✓
Howard County General Hospital	✓				
Johns Hopkins Hospital	✓	✓	✓	✓	✓
MedStar Franklin Square Hospital Center	✓				
MedStar Good Samaritan Hospital			✓		
MedStar Montgomery General Hospital				✓	✓

⁶⁵ American Telemedicine Association, *What is Telemedicine and Telehealth?*

⁶⁶ InMedica, *The World Market for Telehealth – An Analysis of Demand Dynamics – 2012*. (January 2013).

⁶⁷ InMedica, *The World Market for Telehealth – An Analysis of Demand Dynamics – 2012*. (January 2013).

⁶⁸ MHCC, *Health Information Technology: An Assessment of Maryland Hospitals* (2013).

⁶⁹ MHCC, *Health Information Technology: An Assessment of Maryland Hospitals* (2013).

Hospital	Imaging	Diagnostic	Monitoring	Emergency	Consultation
MedStar St. Mary's Hospital					✓
Mercy Medical Center	✓			✓	
Meritus Medical Center	✓				✓
Peninsula Regional Medical Center	✓	✓	✓		✓
Suburban Hospital	✓				
Union Hospital of Cecil County			✓		
University of Maryland Medical Center	✓				
	14	7	8	6	11

Maryland hospitals that are using telemedicine were asked to identify the type of technology they use for telemedicine. About 75 percent of hospitals that are using telemedicine are using desktop software. In general, desktop technology expanded for telemedicine use does not necessarily require purchasing additional equipment. The following table indicates the type of technology used by hospitals to provide telemedicine services.⁷⁰

Hospital	Desktop	Handheld Wireless	Home Devices	Interactive Video	Robotics
Anne Arundel Medical Center	✓				
Atlantic General Hospital	✓			✓	
Bon Secours Baltimore Health System					✓
Calvert Memorial Hospital	✓	✓		✓	
Carroll Hospital Center			✓		
Doctors Community Hospital	✓	✓		✓	
Frederick Memorial Hospital	✓	✓		✓	
Holy Cross Hospital	✓		✓	✓	
Howard County General Hospital	✓			✓	
Johns Hopkins Hospital	✓		✓	✓	
MedStar Franklin Square Hospital Center	✓				
MedStar Good Samaritan Hospital		✓			
MedStar Montgomery General Hospital	✓			✓	
MedStar St. Mary's Hospital			✓		
Mercy Medical Center	✓				
Meritus Medical Center	✓	✓			
Peninsula Regional Medical Center				✓	
Suburban Hospital	✓				
Union Hospital of Cecil County	✓			✓	
University of Maryland Medical Center	✓			✓	
Totals	15	5	4	11	1

Maryland Physicians

⁷⁰ MHCC, *Health Information Technology: An Assessment of Maryland Hospitals* (2013).

Recent data collected from Maryland physicians indicate that about 10.2 percent of physicians are using telemedicine for purposes of diagnosis, second opinion, follow-up, chronic disease, and emergency care, among others.⁷¹ Ad hoc discussions with various office-based physicians regarding telemedicine adoption identified several areas of concern: the lack of confidence with the technology, a lack of understanding about reimbursement opportunities, and the limited nature of the reimbursement opportunities that do exist (such as the geographic restriction on the patient location for Medicare patients and more prevalent restrictions on reimbursement for care delivered to a patient in his or her home).

Maryland Health Care Organizations

Currently, payment reform initiatives initiated by the Affordable Care Act (ACA), are generating interest in telemedicine among many provider organizations that had not considered it previously. Value-based reimbursement models⁷² make it possible for organizations to incorporate telemedicine into new models of care, as compared to the current fee-for-service model. In value-based reimbursement models, providers receive increased reimbursement when patient outcomes improve. Hospital readmission penalties introduced by the Centers for Medicare and Medicaid Services are driving providers to adopt telehealth as a means of reducing readmissions.⁷³ Telemedicine can be used to remotely monitor and engage patients, to reduce the need for office visits, or to prevent hospital admissions. Delivering health care services virtually can be more convenient for physicians and hospitals and enable them to serve more people. The use of telemedicine to diagnose and prescribe treatment for common ailments may become an essential alternative to in-person consultations.

As part of the environmental scan, two value-based reimbursement models emerging in Maryland are planning to use telemedicine as a way to improve care delivery and control costs. Funding for the initiatives is through federal grants under the ACA, allowing for upfront investments in technology and training that would otherwise have to be absorbed by individual practices. MedChi, The State Medical Society, plans to use telemedicine in three accountable care organizations (ACOs).⁷⁴ MedChi will implement a “telemetric call center” where nurses and community health workers will monitor data feeds from the homes of its most at-risk patients. The patients will be provided blood pressure cuffs and other monitoring devices; they will be contacted proactively when regular readings are not received. Evergreen Health Cooperative, a health insurance cooperative in Baltimore City, intends to utilize telemedicine to foster collaboration and communication among members of its patient-centered care teams. Specialists will be accessible via live videoconference from the primary care office.

⁷¹ 2012 Board of Physician Licensure file. A database of physician responses to the bi-annual licensure survey.

⁷² Value-based reimbursement models allow providers to earn a bonus or share of the savings generated by keeping a cohort of patients healthy.

⁷³ InMedica, *The World Market for Telehealth – An Analysis of Demand Dynamics – 2012*. (January 2013).

⁷⁴ According to CMS (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/>), Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

Retail Health Clinics

Retail health clinics, including those located in pharmacies and supermarkets, are beginning to develop telemedicine programs.⁷⁵ Most notably, the Rite Aid pharmacy chain recently extended its NowClinic program, through which patients may consult via videoconference with a physician in a private room inside a pharmacy, from Michigan to 58 locations in multiple states including Maryland. The NowClinic program is being jointly developed by Rite Aid, American Well and OptumHealth, a division of United Health Group.⁷⁶ Physicians are contracted by OptumHealth to provide services through the program. Other national pharmacy chains are exploring similar programs.⁷⁷ Walmart, which has opened retail health clinics in numerous store locations, has begun a pilot in Pennsylvania of a similar telemedicine program.⁷⁸ One concern about the growing utilization of retail health clinics is that telemedicine could encourage ineffectively-coordinated care.⁷⁹

Technology Vendors

Telemedicine technology is largely siloed and based on specific use cases with certain specialties' use of telemedicine advancing faster than others.⁸⁰ Widespread deployment of telemedicine across a service area, such as a region or state, is typically limited to pilots and generally relies on proprietary hardware and software. To increase the use of interconnected telemedicine solutions, constraining the broad range of standards that exist today is required. Telemedicine vendors offer unique solutions to hospitals, such as carts, routers, and switches, as well as a range of business models catering to very specific use cases. National certification of vendor products and harmonizing standards could increase interoperability among telemedicine solutions and help facilitate widespread adoption of the technology.

Remarks

Telemedicine is essential in expanding the availability of health care, improving patient experience and outcomes, and addressing the affordability of care. Telemedicine enables the implementation of new models of care delivery to improve access to health care, such as virtual practice groups, which are networks of providers who are available to consult with patients or their providers via telemedicine. ACOs also create opportunities for the use of telemedicine as part of new, innovative models of care. Although telemedicine technology has advanced in recent years, diffusion related to the number of services provided via telemedicine remains low.⁸¹ A number of opportunities exist for office-based physicians and hospitals to use telemedicine to improve care delivery. Challenges

⁷⁵ Media Health Leadership, *Telemedicine is Retail Health Clinics' Newest Tool* (June 2013). Available at: <http://www.healthleadersmedia.com/page-1/TEC-291947/Telemedicine-is-Retail-Health-Clinics-Newest-Tool>.

⁷⁶ California Telehealth Resource Center, *Markets in Everything: Virtual Retail Clinics* (February 2012). Available at: <http://www.caltrc.org/telehealth-news/markets-everything-virtual-retail-clinics>.

⁷⁷ Drug Store News *Telehealth can Further Expand Retail Clinic Model* (February 2013). Available at: <http://drugstorenews.com/article/telehealth-can-further-expand-retail-clinic-model>.

⁷⁸ PRLog *Smart Care Doc™ Operated by Telemed Ventures, LLC Opens Retail Telemedicine Clinic* (May 2012). Available at: <http://www.prlog.org/11881736-smart-care-doc-operated-by-telemed-ventures-llc-opens-retail-telemedicine-clinic-at.html>.

⁷⁹ HealthWorks Collective *Retail Clinics and Telemedicine* (June 2012). Available at: <http://healthworkscollective.com/rdowney14/34428/retail-clinics-and-telemedicine>.

⁸⁰ Jamie Yap, *Telemedicine Adoption 'Disappointing' So Far*. (February 2012). Available at: <http://www.zdnet.com/telemedicine-adoption-disappointing-so-far-2062303896/>.

⁸¹ Tanriverdi H., Iacono C.S. *Diffusion of Telemedicine: A Knowledge Barrier Perspective*. Telemedicine Journal (Fall 1999).

around technology and identifying the appropriate use cases need to be resolved if telemedicine is to be embraced by the provider community.

End quoted text

Appendix N: Advisory Group Discussion Topics

The below topics of discussion are aimed at achieving the requirements of Senate Bill 776, *Telemedicine Task Force – Maryland Health Care Commission* (SB 776) and have been assigned to the Telemedicine Task Force Clinical Advisory Group.⁸²

Clinical Advisory Group	Technology Solutions and Standards Advisory Group	Finance and Business Model Advisory Group
The role of telemedicine in advanced primary care delivery models; innovative service models for diverse care settings	Supportive uses of electronic health records and health information exchange	Applications for cost-effective telehealth
Use cases for evaluation (e.g. stroke, dermatology, emergency services, etc.)	Emerging technology and standards for security	Innovative payment models
Patient engagement, education and outcomes	Identify strategies for telehealth deployment in rural areas to increase access to health care	Public and private grant funding
Health professional productivity, resources and shortages; underserved population areas		Identify strategies for telehealth deployment to meet any increased demand for health care due to the implementation of the ACA

⁸² *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session). Available at: http://mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf. See Appendix A.

Appendix O: Advisory Group Guiding Principles

The Clinical Advisory Group and the Technology Solutions and Standards Advisory Group developed guiding principles to direct their discussions, as outlined below.

Clinical Advisory Group

- The CAG should look beyond telemedicine and include discussions of and recommendations for other telehealth interventions such physical therapy, speech therapy, home health monitoring, mental health, and others.
- While access to telehealth services in rural areas is of particular concern, the use of telehealth should be encouraged and reimbursed when best practices support improved access, improved clinical outcomes, improved health professional productivity, and cost savings regardless of the geographical location of the patient.
- The CAG should attempt to align its work with state and national health care priorities.
- Barriers to the licensing and credentialing of telehealth providers should be addressed, but should remain sufficiently robust to ensure patient safety and quality of care.
- Telehealth networks should be interoperable by whatever means is most feasible and cost effective.
- Consumers as well as health care providers should be educated on the appropriate uses and benefits of telehealth.
- The CAG will develop recommendations that enable synergies with the Technology Solutions and Standards as well as the Finance and Business Model Advisory Groups.

Technology Solutions and Standards Advisory Group

- Foster patient-centered telemedicine solutions that allow for the measurement of quality and clinical outcomes
- Allow the marketplace to develop technology solutions with minimal State requirements, consistent with industry standards that enable interoperability, and in compliance with federal and State privacy and security laws
- Identify technical approaches that enable telemedicine to be a component of innovative care delivery models
- Propose telemedicine solutions that incorporate the use of health information exchange and electronic health records

Appendix P: Telemedicine Standards and Guidelines

The American Telemedicine Association develops and maintains standards and guidelines for telemedicine, which are intended to set a national baseline for high-quality care delivered via telemedicine. This work is conducted using a rigorous peer-review process. Current standards and guidelines are included below. Additional information is available at: www.americantelemed.org.

- [Practice Guidelines for Video-Based Online Mental Health Services](#)
Covering provision of mental health services when using real-time videoconferencing services via Internet, including a personal computer with webcam or mobile communications device with two-way camera capability. (May 2013)
- [Quick Guide to Store-Forward and Live-Interactive Teledermatology for Referring Providers](#)
Concise overview of work-flows, equipment requirements, and best practices for both Live (synchronous) and Store-and-Forward (asynchronous) teledermatology. (April 2012)
- [Expert Consensus Recommendations for Videoconferencing-Based Telepresenting](#)
Administrative, technical, and clinical standards for using videoconferencing-based telepresenting to connect patients with remote medical providers. (October 2011)
- [Telehealth Practice Recommendations for Diabetic Retinopathy](#)
Covers designing, implementing, and sustaining ocular telehealth program. (February 2011)
- [A Blueprint for Telerehabilitation Guidelines](#)
Key administrative, clinical, technical, and ethical principles that should be considered in providing telerehabilitation services. (October 2010)
- [Practice Guidelines for Videoconferencing-Based Telemental Health](#)
Guidelines to assist in development and practice of coherent, effective, safe, and sustainable telemental health practices. (October 2009)
- [Evidence-Based Practice for Telemental Health](#)
Companion piece to the American Telemedicine Association's Practice Guidelines for Videoconferencing-Based Telemental Health, with reference and support for decision-making in developing and providing telemental health services. (July 2009)
- [Core Standards for Telemedicine Operations](#)
Requirements for providing remote medical services, interactive patient encounters, and any other electronic communications between patients and practitioners. (February 2008)
- [Practice Guidelines for Teledermatology](#)
Covers practice of effective, safe, and sustainable teledermatology. (December 2007)
- [Home Telehealth Clinical Guidelines](#)
Diverse applications for home telehealth technology with universal principles guiding future development and deployment of home telehealth. (2003)
- [Clinical Guidelines for Telepathology](#)
Clinical guidelines for telepathology, applicable to: static (store and forward), dynamic (synchronous), and hybrid (static-dynamic) implementations. (May 1999)

Appendix Q: Core Telemedicine Operational Standards

The American Telemedicine Association published core telemedicine operation standards which may be used as a guide by organizations selecting and implementing telemedicine technology.⁸³

Begin quoted text

Administrative Standards

Organizations

1. Organizations providing services via telehealth shall follow the standard operating policies and procedures of the governing institution. If the telehealth operation is a sole entity or part of a solo practice, that entity or solo practice shall have policies and procedures in place to govern all administrative functions that responsibly include and address aspects of telehealth with regards to:
 - a. Human resource management
 - b. Privacy and confidentiality
 - c. Federal, state, and other credentialing and regulatory agency requirements
 - d. Fiscal management
 - e. Ownership of patient records
 - f. Documentation
 - g. Patient rights and responsibilities
 - h. Network security
 - i. Telehealth equipment use
 - j. Research protocols
2. Organizations providing telehealth programs shall have in place a systematic quality improvement and performance management process that complies with any organizational, regulatory, or accrediting, requirements for outcomes management.
3. Organizations and health professionals providing telehealth services shall ensure compliance with relevant legislation, regulations, and accreditation requirements for supporting patient/client decision-making and consent, including protection of patient health information.
4. Organizations shall have a mechanism in place for assuring that patients are aware of their rights and responsibilities with respect to accessing health care via telehealth technologies, including the process for communicating complaints.

⁸³ American Telemedicine Association, November 2007. *Core Standards for Telemedicine Operations*. Available at: <http://www.americantelemed.org/docs/default-source/standards/core-standards-for-telemedicine-operations.pdf?sfvrsn=4>.

5. Organizations shall integrate telehealth into the existing operational procedures for obtaining consent for treatment from patients and organizations shall provide a mechanism for additional informed consent when required for invasive procedures.
6. Organizations providing telehealth services that establish collaborative partnerships shall be aware of applicable legal and regulatory requirements for appropriate written agreements, memorandum of understanding, or contracts. Those contracts, agreements, etc., shall be based on the scope and application of the telehealth services offered, and, shall address all applicable administrative, clinical, and technical requirements.

Health Professionals

1. Health professionals providing telehealth services shall be fully licensed and registered with their respective regulatory/licensing bodies and with respect to the site where the patient is located, administrative, legislative, and regulatory requirements.
2. Health professionals providing telehealth services shall be aware of credentialing requirements at the site where the consultant is located and the site where the patient is located, in compliance with and when required by regulatory and accrediting agencies.
3. Health professionals shall be aware of their locus of accountability and any/all requirements (including those for liability insurance) that apply when practicing telehealth in another jurisdiction.
4. Health professionals using telehealth shall be cognizant of when a provider-patient relationship has been established within the context of a telemedicine encounter between the health care provider and the patient, whether interactive or store-and-forward, and proceed accordingly with an evidence-based, best possible standard of care.
5. Health professionals providing telehealth services shall have the necessary education, training/orientation, and ongoing continuing education/professional development to ensure they possess the necessary competencies for the safe provision of quality health services in their specialty area.

Clinical Standards

1. The organization and health professionals shall be satisfied that health professionals providing care via telehealth are aware of their own professional discipline standards and those standards shall be upheld in the telehealth encounter, considering the specific context, location and timing, and services delivered to the patient.
2. Health professionals shall be guided by professional discipline and national existing clinical practice guidelines when practicing via telehealth, and any modifications to specialty-specific clinical practice standards for the telehealth setting shall ensure that clinical requirements specific to the discipline are maintained.

Technical Standards

1. Organizations shall ensure that equipment sufficient to support diagnostic needs is available and functioning properly at the time of clinical encounters.

2. Organizations shall have strategies in place to address the environmental elements of care necessary for the safe use of telehealth equipment.
3. Organizations shall comply with all relevant safety laws, regulations, and codes for technology and technical safety.
4. Organizations shall have infection control policies and procedures in place for the use of telehealth equipment and patient peripherals that comply with organizational, legal, and regulatory requirements.
5. Organizations providing telehealth services shall have policies and procedures in place to comply with local legislated and regulatory rules for protection of patient health information and to ensure the physical security of telehealth equipment and the electronic security of data.
6. Organizations shall have appropriate redundant systems in place that ensure availability of the network for critical connectivity.
7. Organizations shall have appropriate redundant clinical video and exam equipment for critical clinical encounters and clinical functions.
8. Organizations shall meet required published technical standards for safety and efficacy for devices that interact with patients or are integral to the diagnostic capabilities of the practitioner when and where applicable.
9. Organizations providing telehealth services shall have processes in place to ensure the safety and effectiveness of equipment through on-going maintenance.

End quoted text



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