


Telemedicine and MPL: The Story So Far





BY DANA MURPHY

What we're learning from the PIAA Data Sharing Project



Telemedicine, widely hailed as a breakthrough in healthcare communications, is already proving its worth to both patients and healthcare professionals. It can range from a brief conversation over the phone about a new symptom, to a cutting-edge system that links remote monitoring of vital signs like temperature and blood pressure to software that interprets them and sends warning alerts to caregivers.

But there are some important concerns about this evolving technology, in regard to potential repercussions for the medical professional liability (MPL) insurance community. Key considerations include newly challenging issues such as licensure, informed consent, and continuity of care.

At present, there are relatively few closed claims involving telemedicine in the PIAA Data Sharing Project (DSP) database. But with telemedicine still relatively new, at a time when the potential applications of it are multiplying rapidly, it is prudent to be cautious in extrapolating from what has occurred to date and applying that to numbers of future claims.

With this caveat in mind, this article also provides information and analysis on the current telemedicine claims stored in the PIAA DSP, along with some tips for prudent risk management in using telemedicine.

What is telemedicine?

The term “telemedicine” has been applied to such a wide range of applications that it is easy to become confused about what this actually means. The Centers for Medicare & Medicaid Services’ (CMS) website defines it this way:

A two-way, real-time interactive communication between a patient and a physician or practitioner at a distant site through telecommunications equipment that includes, at a minimum, audio and visual equipment.

The American Telemedicine Association (ATA) defines “telemedicine” this way:

The use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology.

The use of telemedicine, and reimbursement for it, is expected to expand in the coming years, but especially in rural areas where there are few or no primary care givers.

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Telemedicine: possible areas for growth

CMS has been expanding the list of services that can be furnished through telehealth. In 2012, smoking cessation services were added. In addition, CMS changed the criteria for adding services to the telehealth reimbursement list, to focus on the clinical benefit of making the service available through telehealth.

In terms of limits on location, Medicare reimburses for telehealth services when they are provided from a rural originating site (where the patient is), that is, in a Health Professional Shortage Area (HPSA) or in a county that is outside of any Metropolitan Statistical Area (MSA), defined by the Health Resources and Services Administration and the Census Bureau, respectively.

The Medicaid program would appear to be encouraging telemedicine, as a way “to improve a patient’s health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site.” It is seen “as a cost-effective alternative to the more traditional face-to-face way of providing medical care that states can choose to cover under Medicaid” (CMS website).

Also, telemedicine holds particular promise for patients living in rural and isolated communities, who can receive care via this medium from doctors or specialists at remote sites, without having to travel lengthy distances to visit them. Many studies are investigating the effectiveness of telemedicine, relative to traditional in-person clinical care, for improving the health of persons in rural America.

In one study of teler dermatology in rural Veterans Administration clinics, for example, 71% of healthcare professionals said they were satisfied or very satisfied with the project, and 86% stated that this was a good addition to their regular patient services. But they also noted problems with an increased workload due to more dermatology visits related to dermatology care, and limited support for the information technology that was used in providing the telemedicine consult (Telemedicine and e-Health, September 13, 2013).

Issues for telemedicine

Despite the generally acknowledged advantages of telemedicine, there are several ongoing issues that may serve to limit its full potential.

These issues may also emerge as key elements in MPL claims from patients who receive care via telemedicine.

Jurisdictional diversity and licensure. Physicians and others who provide care to patients in a different legal jurisdiction than their own—usually, this means in another state—engage the historical, complex area of law called “conflict of laws.” If a practitioner licensed only in jurisdiction A treats a patient in jurisdiction B, he may be violating B’s laws. Or, a practitioner in A who violates a contract or treats a patient in B negligently may incur liability in B, A, or both.

Lack of licensure portability for physicians and mid-level practitioners is the most significant legal barrier to greater adoption of telehealth nationwide. Under most state laws, physicians and mid-level practitioners must be licensed in the state where they normally practice. If the patient being treated resides across state lines, a practitioner usually must also be licensed in that state to deliver remote services. This creates operational and administrative burdens for physicians who care for patients virtually, in multiple states, through telemedicine.

There is inconsistency, from one state to another, in how telemedicine is regulated. Not all states address telemedicine and the related issue of licensure. However, there are useful compilations of state laws on licensure and scope of practice available online. In April, the Federation of State Medical Boards (FSMB) announced an initiative to explore the use of interstate compacts to simplify telehealth licensing.

In light of the confusion in regard to jurisdictional diversity, many healthcare professionals have concluded that the only way individuals can utilize telemedicine with equanimity is to:

- Provide telemedicine services only to patients who reside in the state where they are licensed
- Obtain the necessary license to practice medicine/nursing in every state in which they may wish to use telemedicine
- Practice within the parameters of the narrow exemptions most states have established to their “unauthorized practice” laws for out-of-state physicians and nurses who act as (infrequent) consultants to in-state practitioners (at the in-state physician’s request) or who assist in emergencies.



Photo courtesy of AMD Global Telemedicine and Stanley Rowin Photography

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H.R. 3077, the TELEhealth for MEDicare Act (TELE-MED), was one effort to address these concerns. The bill would have allowed health-care professionals who are Medicare providers and are licensed to practice physically in one state to be able to treat Medicare patients electronically in any other jurisdiction.

It would also permit a healthcare professional who has been granted a license to physically provide care within a state or jurisdiction to become a Medicare provider, to provide care electronically to those with whom they have an established patient-provider relationship regardless of where the patient is located in the United States. Unfortunately, this bill died in a previous session of Congress when it was referred to Committee.

However, a spokesman from the ATA noted that by the end of the 113th Congress, there were more than 120 backers, combined, for H.R. 3077 and H.R. 2011, a similar bill that pertains to the Department of Veterans Affairs (the Veterans E-Health & Telemedicine Support Act).

Given that support for these sorts of bills has been, to date, virtually bipartisan, the ATA is optimistic that this Congress may be able to pass some substantial law revising policy on telemedicine.

Quality of medicine. Precisely what constitutes quality care as provided by telemedicine is another evolving (and therefore ambiguous) challenge in using telemedicine. However, guidelines have been published by the ATA. For example, there is the ATA's "Core Standards for Telemedicine Operations" (published in 2008), as well as numerous guides published by the various medical specialty groups. The American College of Radiology, for instance, offers "Practice Guidelines for Digital Radiography," published in September 2012.

Quality of technology. The specific technology employed in practicing telemedicine can introduce another limiting factor in its optimal application. Technology can range from the cutting-edge processes discussed in articles such as "Infrared thermal imaging for automated detection of diabetic foot complications" (Journal of Diabetes Technology, September 2013) to a five-minute telephone conversation between a patient and provider. However, whenever feasible, the sophistication of the technology being used should be appropriate for the type of communication application being used.

Limitations in technology may be linked with problems in diag-

nosis or treatment. The information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by a physician and a distant specialist. There may be delays in medical evaluation and treatment that result from deficiencies or failures of the equipment, or power outages.

Other unique challenges in telemedicine include the issue of what sorts of advanced training—if any—should be required of healthcare providers who wish to use telemedicine, and whether providers feel fully confident that they are providing the best possible care, in light of the inevitable limitations (at present) in what can be effectively communicated via telemedicine.

The patient-provider relationship and informed consent

Rules governing the establishment of a physician-patient relationship may be another obstacle to the growth of telehealth services. In many states, a physician-patient relationship is created once a practitioner has an opportunity to take a patient's medical history and conduct an in-person physical exam. As a result, in a majority of states, physicians are prohibited from remotely prescribing medications without first conducting an in-person physical exam.

Also, some states require that practitioners conduct in-person exams before they can provide certain telehealth services to patients who are based in the home or in other settings where a healthcare provider is not physically present.

However, even for states that do not directly or indirectly address telemedicine in their medical licensing laws or define the location of the practice of medicine, it is generally assumed that any act of diagnosing or recommending treatment is the practice of medicine.

Typically, states require that the providers obtain written prior consent before any telemedicine communication can take place. The specific provision from the State Medical Board of California states: *Requires the practitioner to obtain verbal and written informed consent from the patient prior to delivering health care via telemedicine, and also requires that this signed written consent statement becomes part of the patient's medical record.*

Other state medical boards offer additional guidance in their



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statements on informed consent in telemedicine. Regarding what must be said about potential risks with this medium. The Policy Committee of the North Carolina State Medical Board states that,

The physician using telemedicine should obtain the patient's informed consent before providing care via telemedicine services. In addition to information relative to treatment, the patient should be informed of the risks and benefits of being treated via telemedicine. This includes how to receive follow-up care or assistance in the event of an adverse reaction to the treatment or in the event of an inability to communicate as a result of a technological or equipment failure. The patient retains the right to withdraw his or her consent at any time.

Note that the existence of a relationship between the physician and the patient must be established before an MPL action can be filed.

Finally, one particularly challenging issue in regard to telemedicine is continuity of care. The healthcare professional involved in the communication may be limited in not having access to the patient's medical records. He may not know the names and professional affiliations of the other healthcare professionals who provide care to the patient, nor be able to track and ascertain that there has been appropriate and sufficient follow-up after the telemedicine encounter.

However, in any event, the telemedicine patient visit should always be documented in the patient's medical record, and all of his healthcare professionals should be informed about the encounter, and what has been recommended as follow-up after it.

PIAA Data Sharing Project and telemedicine

The PIAA DSP, established in 1985, is the largest ongoing, independent database of MPL claims, containing both medical and dental claims.

Both healthcare professionals and entities are included.

The data captured in the DSP focus on:

- General information
- Patient and insured demographics
- Location of loss
- Resolution
- Loss description and causation.

Of the total claims in the DSP, 94,228, during 2004-2013, a total of 196 were linked with telephone treatment. Of these, 56 resulted in a payment. The percentage of paid-to-closed claims was 28.6% (versus 26.3% for the 24,793 total paid claims in the DSP).

The total indemnity for telephone treatment was \$17 million, versus \$8 billion for the total DSP. The average indemnity was slightly lower, \$303,691, for telephone treatments, versus \$328,815 for the total DSP. Total ALAE costs were \$10 million, versus \$3.9 billion for the total claims in the DSP.

In looking at mobile health (mHealth) as a setting for advice and treatment, "hospital" was the most common setting for an incident giving rise to a claim (linked with 55,606 claims) followed by "practitioner's office" (24,351 claims). "Telephone treatment," in this list, ranked 13th, right after "lab outside hospital," which was linked with 198 claims.

As the chief medical factor involved in the allegation, most closed claims named diagnostic error (9 paid claims), failure to properly respond (13 paid claims) resulted in the highest total and average indemnity, and medications errors (14 paid claims) with the highest paid-to-closed ratio as the chief medical factor involved in the allegation.

Telemedicine: issues for healthcare professionals and insurers

Some of the issues, for healthcare professionals, in regard to mHealth parallel those seen in studies of telephonic medicine. Others are relatively new, for example, various categories of clinical data may be held in isolated silos on the patient's mobile device.

There may also be a failure to centralize all of the documentation generated by mHealth apps and traditional in-person visits, and a lack of coordination among the healthcare professionals if the patient has several of them.

With all of these factors in play, healthcare professionals have a responsibility to address the exposures that are unique to their practice with their MPL insurer. They need to provide explicit information on their use of a website to deliver care or a consultation, including how often they use it, what fee is charged for such consultations, and how they obtain informed consent for these sessions.

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Liability considerations

There are obviously privacy-related issues in play with telemedicine, whether it is conducted via the Internet, a tablet, or a mobile phone. Problems like identity theft persist, despite ever greater attempts at security. There may also be issues linked to discrepancies between self-reporting of data and the actual, measured values. Patients with diabetes, for example, may be tempted to relay to their healthcare professional blood glucose levels that are considerably better than what their glucometer actually shows.

No healthcare professional should forget the advantages of an in-person visit. There, the whole person is visible, and subtleties in physical condition and affect can be directly perceived, and queried if necessary.

Having clear contingency plans in mind is also very important. Both healthcare professionals and MPL insurers should also focus on the potential issues with:

- Secure computer network systems
- Protocols for web cams and web-based portals
- The privacy of others
- Communication—how best to achieve a medium clinically effective for the patient, which makes the most efficient use of the provider's scarce time.
- Finally, everyone involved in the adoption of telemedicine needs to consider what might happen if it is not used.

Risk management for telemedicine use

In the rapidly evolving field of mHealth, the landscape of possible MPL risks will no doubt mutate just as quickly. But, based on the DSP analysis of the closed-claim history with telemedicine, there are some important steps that healthcare professionals can take, to limit their exposure to MPL suits with mHealth.

Meet the licensing requirements. Healthcare professionals should ascertain that they have complied with the applicable licensing requirements in the jurisdictions where they will be using telemedicine. They should ask:

- Do you meet the applicable credentialing requirements established by the hospital or healthcare setting?
- Have technological standards been established, and if so, are you in compliance?

Develop patient encounter protocols. What happens during the various telemedicine sessions should be standardized, to the extent possible, to avoid miscommunications and other potential errors.

Discuss the risk of care, as well as the risk of telemedicine. Patients should be fully informed about what can go wrong in using telemedicine, versus in-person encounters. They should also understand the overall risks involved in the provision of any medical diagnosis or treatment.

Seek legal advice. Healthcare professionals should consult their MPL carrier to learn everything they can about the risks involved with telemedicine and how best to take preventative action to avoid them.

While the risks inherent in using telemedicine are principally an issue for physicians at this point, there is no doubt that they will impact physician extenders and nurses in the future.

Conclusion

While there are relatively few claims in the PIAA DSP involving telemedicine at this point, this medium is still in development, and it is impossible to predict how it may eventually come to be used, and what MPL risks will result from those applications.

But there is also a countervailing argument. Risks may in fact decrease, as more healthcare professionals become familiar and comfortable with telemedicine, and as patients learn how best to utilize it. Much of what eventually emerges as allegations of malpractice arises from skewed expectations among patients. If expectations about what can reasonably be accomplished using telemedicine—for both healthcare professionals and patients—are realistic, the MPL frequency should be contained.

The claims history in the DSP, meanwhile, provides invaluable insights on what healthcare professionals and insurers should do to minimize the risk of telemedicine-related allegations of provider error. [PIAA](#)



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