

TENNESSEE BOARD OF MEDICAL EXAMINERS

Telemedicine Rulemaking Workgroup Session

Monday, July 21, 2014

MINUTES

The meeting of the Board of Medical Examiners' Telemedicine Workgroup was called to order at 2:12 p.m. in the Iris Room, Ground Floor, Metro Center Complex, 665 Mainstream Drive, Nashville, Tennessee 37243. Board of Medical Examiners President, Michael Zanolli, MD, presided over the meeting.

Board members present: Michael Zanolli, MD
Subhi Ali, MD
Dennis Higdon, MD
C. Allen Musil, MD
Reeves Johnson, MD
Michael Baron, MD
Jeff Lawrence, MD
Neal Beckford, MD
Nina Yeiser, Consumer Member
Pat Eller, Consumer Member
Barbara Outhier, Consumer Member

Board member(s) absent: Dr. Keith Lovelady

Staff present: Rosemarie Otto, Director Health Related Board
Maegan Carr Martin, BME Executive Director
Andrea Huddleston, Deputy General Counsel
Stacy Tarr, Unit Manager
Angela Lawrence, Board Administrator
Jennifer Shell, Administrator

Dr. Zanolli began the hearing with a roll call of the board members followed by an overview of the day's session. Dr. Zanolli explained that the group seeks to refine its understanding of telemedicine, incorporate all comments received, and determine how best to shape the rule to increase access and protect patients.

Andrea Huddleston gave an overview of the rulemaking process and directed the Board's attention to binders containing all of the previously submitted written responses for the purpose of review if needed. The audio comments were recorded and can be reviewed as necessary. Ms. Huddleston stated that all changes made to the rule, must be within the scope of the original notice of rulemaking, which is somewhat open to interpretation. If any changes do not fall within the scope of the original notice, a new notice would be required, although comments could be limited to the new material.

Reports from Workgroup Members:

Dr. Zanolli gave a presentation which identified the considerations and basic premises which should and have shaped the Board's discussion of telemedicine to date. First, he explained that the application of this new technology is the practice of medicine and it occurs where the patient is located. Second, there is an important distinction in new encounters and established encounters and the way in which the Board should treat these respective encounters. Dr. Zanolli also presented some of the highlights of and background on the Federation of State Medical Boards' (FSMB) "Model Policy for Appropriate Use of Telemedicine Technologies in the Practice of Medicine."

Ms. Eller presented the board with information concerning how to distinguish "telehealth" from "telemedicine." Generally, telehealth is broader and won't always involve clinical services whereas telemedicine requires the provision of clinical services. Accordingly, telehealth may include medical education, administration and research. Ms. Eller reported that CMS began reimbursing for telemedicine services this year. States have the option to reimburse for Medicaid services provided through telemedicine.

Dr. Johnson sought to compare and contrast the Board's proposed definition of telemedicine with Public Chapter 675¹ as well as definitions from the relevant FSMB and American Medical Association (AMA) policies. Dr. Johnson stated that he believes that the proposed definition is broader than Public Chapter 675. Dr. Johnson also provided the Board with information on patient centered medical homes (PCMH), which is an accreditation product developed by the National Committee on Quality Assurance (NCQA). The NCQA has developed a draft policy that seeks to assure that increased utilization of telemedicine won't fragment care. A copy of the draft policy was provided to the Board.

Dr. Musil provided an overview of how the issue of stimulant and controlled substance prescribing via telemedicine is regulated from state to state. He reported that a majority of states require that a doctor-patient relationship be established before prescriptions are written and prohibit internet/online questionnaires to establish a doctor-patient relationship. He suggested that there is likely some overlap between e-prescribing and telemedicine regulations. Dr. Musil also provided some examples of exceptions to these commonly accepted provisions;

¹ Public Chapter 675 permits telehealth providers to contract with insurance companies to have their services covered in offered plans. Insurance providers cannot deny payment solely because the encounter wasn't in-person.

for example, in Louisiana, only board certified physicians may use telemedicine to prescribe amphetamines or narcotics. In Ohio, a physician may not prescribe or dispense a dangerous drug without physically examining and diagnosing the patient first (unless an exception applies).

Dr. Higdon presented information concerning Emergency Medical Technicians (EMTs) and current physician supervision and the ways in which telemedicine might improve their performance. Dr. Higdon described a process by which some EMTs might complete follow-up visits with patients who were recently seen by physicians through the use of telemedicine to transmit information back to the treating physician. This process, called community paramedicine, is particularly valuable in remote areas. Dr. Higdon raised the question of how this information might be regulated by HIPAA and how it should be protected.

Discussion of Proposed Telemedicine Rule:

Dr. Zanolli suggested that the workgroup work to identify areas of consensus within the proposed rule and continue working on areas that require further attention.

The introductory paragraph at 0880-02-.16 was approved by the group.

As a matter of efficiency, Dr. Zanolli suggested that the workgroup leave further discussion of the definitions contained at subsection (1) until all other issues have been addressed.

Dr. Zanolli explained that subsection (2) “Telemedicine Licenses Issued Under Previous Rule” is a necessary provision to transition those who currently have a telemedicine license to the new rule, which requires full licensure to practice telemedicine. Ms. Huddleston stated that the original rule contemplated telemedicine by radiologists and pathologists. Dr. Beckford asked whether the Board should require board certification for physicians practicing telemedicine when it doesn’t require board certification for fully licensed physicians. Ms. Eller raised concerns regarding the inconsistency of no longer granting telemedicine licenses but letting those grandfathered in, keep their licenses. Ms. Huddleston explained that to do otherwise would raise due process issues. The Board compared this subsection to the current requirements of a telemedicine license. The only added restriction is that the telemedicine licensee must maintain board certification.

The Board also directed that subsection (2) be amended to clarify that licensees currently holding a telemedicine license are not required to transfer to a full license within two (2) years of the effective date of this rule; they may apply to transfer their license anytime. However, licensees transferring to a full license more than two (2) years from the effective date of the rule will have to pay a new application fee.

Subsection (3) gives the Board jurisdiction and authority over the license. Dr. Zanolli explained that this is important because these providers may be residing outside the state.

Dr. Zanolli suggested that subsection (4) seeks to carve out certain, current practices, from the telemedicine rule. Subsection(4)(a) contemplates communications/consultations regarding medicine generally, not a specific case. Dr. Zanolli believes subsections (a) and (b) are in the existing rule. Subsection 4(c) refers to the communications/consultations between providers in which a specific case is referenced, but no referral occurs. Dr. Baron questioned whether (b) and (c) are necessary. Dr. Johnson recollected concern by St. Jude regarding this practice. No objections were raised.

The Board discussed subsection (5) which seeks to specify that if you are practicing medicine within a contractual relationship, you must be licensed in Tennessee. The Board determined that it would return to this provision at the next meeting.

The Board skipped subsection six (6) with the intent to return to this section during the meeting.

Dr. Zanolli explained that subsection (7) is specifically for pathologists and radiologists. The osteopathic and allopathic schools have come to an understanding that they will all fall under ABMS. Dr. Beckford stated that, under this rule, a physician who wants to practice intrastate medicine who is no longer board-eligible will be unable to read films because of the requirement that he or she be board-certified. Accordingly, Board determined that this provision would need to be revisited.

Dr. Zanolli provided that subsection (8) is a legal formality and no objections or concerns were raised.

The Board returned to subsection (2) to discuss maintenance of certification. Dr. Johnson suggested the Board adopt the MOC language from the recent amendment to the one (1) point rule. Dr. Baron requested that 2(a) be rewritten. Dr. Johnson asked that (2)(a) be amended to delete the reference to "Tennessee patients" and replace with "patients in Tennessee."

The Board turned its attention to subsection (6). Dr. Zanolli remarked on the widespread interest in the rule, particularly this section, and the quality of the comments received to date. Dr. Zanolli reiterated the Board's primary goals of increased access and patient safety.

The Board began by discussing the facilitator requirement. Dr. Zanolli stated that there are many licensees with the appropriate medical knowledge to facilitate these initial encounters. Dr. Musil suggested that the facilitator be credentialed appropriately in the

patient's continuum of care. Dr. Beckford expressed a preference for a facilitator but questioned how much value they add above what the patient is able to provide. The Board acknowledged minors are somewhat of an exception in that a facilitator is always going to be necessary.

The Board also determined that it is important to verify the identity of the patient; however, it may not be necessary for a facilitator to be present for a provider to have confidence that the person is who they say they are and is presenting for the reason or reasons they specify. One possible solution is to allow two pathways for the initial encounter, either 1) there must be electronic sophistication to enable an appropriate level of confidence of the provider on the other end of a real-time or store-and-forward encounter; or 2) there must be a facilitator present, who holds the appropriate credential.

The Board turned its attention to the definition of telemedicine at (1)(b). Dr. Baron suggested the definition be amended to read: "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 healthcare provider. Generally, telemedicine is not an audio only telephone conversation, email/instant messaging conversation or fax. It typically involves the application of secure video conferencing or store-and-forward, to provide or support healthcare delivery by replicating the interaction of a traditional encounter in-person between a provider and a patient." Dr. Zanolli clarified that this definition likely works for the initial encounter, but may not work for the follow-up as it is quite rigid. The Board determined that texting and email should not be included in the definition. Dr. Musil suggested that the word "generally" be omitted. Ms. Huddleston suggested that the word "generally" be replaced with the phrase, "for the purpose of the initial patient encounter." The Board agreed.

Dr. Zanolli queried the workgroup to determine the feasibility of a follow-up meeting on Monday September 15, 2014 at 2:00pm in the same location. The workgroup agreed to meet at that time.

Adjourned 6:05pm