A Baseline on the State of Telemedicine in Michigan:
Where We Are Now and Where We Are Headed

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Whether it is considered part of a daily routine or merely a futuristic, yet-to-be dabbled-in idea, every health care practitioner is undoubtedly aware of the growing use of technology in providing health care, or "telemedicine." Telemedicine is a concept that has been analyzed by politicians and practitioners alike as a way to expand access to health care, reduce costs, and enhance the practitioner-patient relationship through increased communication avenues.

However, when it comes to actually using telemedicine, practitioners may find themselves faced with a myriad of practical, technical, and ethical considerations. For example, when is it appropriate to use telemedicine? How is it paid for? How does it work? Do Michigan licensing boards approve the use of telemedicine to treat patients?

This paper is intended to serve as a primer for the Michigan health care attorney who must advise his/her clients on the propriety and considerations of using telemedicine. To that effect, the paper will first provide an overview of what exactly the term "telemedicine" encompasses, as well as a summary of important developments which have triggered the growth of telemedicine over the past few years. Next, the article will highlight the key issues which practitioners planning to use telemedicine must consider, drawing upon guidance from national medical associations and groups in the area and juxtaposing such guidance with Michigan law. This discussion pays special attention to salient issues in telemedicine, such as protecting the physician-patient relationship; the use of online or "e-prescribing" practices, the practice of

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medicine across state lines; and privacy considerations. Finally, this paper will touch on the reimbursement of telemedicine services by government and private payors.

A word of caution to practitioners relying on this paper as the last word on telemedicine is in order. Generally speaking, there is a lack of Michigan-specific guidance when it comes to using telemedicine, and until June of 2012 the term "telemedicine" was not defined in Michigan. Although the Michigan Bureau of Health Professions has convened a Workgroup to examine the issues related to the use of technology in the delivery of healthcare and the Workgroup has made recommendations with respect to telemedicine (discussed in detail below), the individual State Licensing Boards have not issued any official guidelines for their respective practitioners to abide by. Further, although in June of 2012 two laws were passed in Michigan requiring Blue Cross Blue Shield and other private insurers to provide coverage (subject to certain restrictions) for care rendered via telemedicine which utilizes real-time video and/or interaction, there is no other Michigan legislation regulating the practice of telemedicine. Accordingly, this article is far from being a final word on telemedicine in Michigan.

Rather, this article seeks to lay out a mere baseline from which legal practitioners can build by developing their own up-to-date and to-the-point legal advice in what is a very broad and legally under-developed area. Put in other words, this paper constitutes only the first installment of an ongoing discussion which, though under-developed at this time, is clearly front and center in the State.

What Is "Telemedicine"?

When advising clients on a topic as broad as telemedicine, it is important to first have an understanding of what the term encompasses. In everyday conversation, "telemedicine" is often

used interchangeably with terms such as "e-health", "electronic health records", and other technologically-affiliated phrases.

According to the Michigan Bureau of Health Professions E-Health Workgroup (hereafter referred to as the "E-Health Workgroup"), "telemedicine" is actually a subset of "e-health," which is an umbrella term that encompasses all practices and issues related to the technologically-facilitated delivery of health care information, education, consultation, products, and services. [1]

Except as otherwise specified, for purposes of this paper, the term "telemedicine" will be based on the E-Health Workgroup definition and refers to the use of any communication or information technologies to facilitate the delivery of clinical care. Examples of telemedicine include a psychiatrist conducting a real-time web-based therapy session with a patient through the use of Skype or web-cameras; email correspondence between a patient and physician regarding a prescribed medication; or a physician uploading a patient's X-rays to an Internet site and sharing the images with a specialist in another state.

As noted above, the practice of telemedicine includes situations where both clinical and non-clinical services (such as medical education, administration, consultation, assessment and research) are provided to patients or shared between providers. E-prescribing is included as a category of telemedicine, as is "cybermedicine," which is the practice of patients and health care providers communicating through the use of electronic mail or web-based chat programs.

Why Use Telemedicine?

There are obvious benefits associated with the use of telemedicine. Most notably, it allows for increased portability and access to health care. For example, telepsychiatry or the use

[1] *See* Michigan Department of Community Health Bureau of Health Professions, *FY 2008 Report and Recommendations of the E-Health Workgroup* (March 2008), at 8 [hereafter *2008 Report*].

of Internet video-conferencing to provide counseling to patients allows a practitioner to treat individuals in rural or inner-city areas where the demand for such services exceeds the supply of licensed professionals.[2] Additionally, telemedicine enhances the number of resources available to providers. Indeed, a physician can use telemedicine to input patient progress notes in an electronic health record (EHR) and then forward the electronic patient file to a second physician for consultation. Further, a physician can use "real time" video for interactions as complex as robotic surgery, whereby a patient and provider are present at the same time with a communications link between them that allows real time video interactions to take place. Furthermore, the increased use of technology, such as e-prescribing, is anticipated to result in drastically reduced administrative costs and medical errors. For example, a 2004 study performed by the Medical Group Management Association shows that administrative costs related to managing prescription refill requests by phone can cost practices more than $10,000.00 per year per physician.[3] As a result of the foregoing, telemedicine is expected to become increasingly relevant as the use of electronic medical records (EHRs) rises.

Another critical reason for the expected increase in the use of telemedicine is a provision of the 2009 American Recovery and Reinvestment Act (a.k.a. the Stimulus Bill), which requires health care providers to make "meaningful use" of electronic medical records by 2011 or be penalized in the form of decreased Medicare and Medicaid payments. Recent proposed rules from the Center for Medicare and Medicaid Services indicate that a provider's use of electronic prescribing and "interoperability" (i.e., the ability to share health information with patients, other providers and government agencies) will be used to gauge whether a provider is making

[2] *See, e.g.*, Megha Satyanarayana, *No Psychiatrist Nearby? Turn On the Screen*, Detroit Free Press, November 15, 2009.
[3] Source: 2004 MGMA – *Analyzing Cost of Administrative Complexity in a Group Practice.*

"meaningful use" of EHR.[4] In light of the foregoing, it is inevitable that telemedicine will become progressively more visible in the everyday practice of medicine and that health care attorneys can expect increased queries from health care clients on how to properly implement telemedicine into their practices. Attorneys will need to be ready to advise health care clients on the following issues:

ESTABLISHING AND PROTECTING THE PROVIDER-PATIENT RELATIONSHIP

IN GENERAL: The use of telemedicine creates the possibility for many "shortcuts" in the provider-patient relationship. Under the traditional model for obtaining medical care, patients commonly locate physicians through phone book listings, their managed care plan, or referrals from another physician. These contacts are followed by an appointment to see the physician for treatment. The physician then meets with the patient and prescribes care based on both physical and verbal examinations. Additionally, the physician may already have obtained background information on the patient; the patient's medical file may have been sent to the physician in advance; or the treating physician may have spoken with the referring physician about the patient. In contrast, with the advent of telemedicine, a patient may simply email a physician describing his/her symptoms and ailments or may submit a query on a physician practice website or blog. The foregoing model for obtaining medical care creates a scenario whereby a patient locates a physician and the physician recommends or prescribe treatments based on merely the patient's verbal representations of his/her illness.

Obviously, several issues arise with this second "treatment" scenario. First, the physician must rely on the patient's accurate representation of information to the physician, as there is no independent way for the practitioner to confirm the patient's illness or ascertain whether there

[4] Centers for Medicare and Medicaid Services, *Medicare and Medicaid Programs: Electronic Health Record Incentive Program*, 75 FR 1844 *et seq*. (January 13, 2010).

are other symptoms present which must be addressed as well. Secondly, during a quick email exchange, the lines may be blurred as to whether a patient-physician relationship has actually been established. Finally, an electronic exchange may adversely impact a provider's ability to provide high-quality health care and may expose a provider to liability by requiring him/her to make decisions about a patient's health without physically examining the patient.

The general consensus amongst professional medical associations is that email or other online queries may not be used as a substitute for face-to-face contact to establish an initial physician-patient relationship. For example, the Federation of State Medical Boards' ("FSMB") *Model Guidelines for the Appropriate Use of the Internet in Medical Practice*[5] sets out that an in-person patient evaluation must be conducted prior to providing any treatment, whether through issuing electronic prescriptions or otherwise. Treatment based solely on an online questionnaire or consultation without a preceding face-to-face evaluation at some point in the physician-patient relationship does not meet the acceptable standard of care.

The FSMB guidelines have been echoed by groups such as the American Osteopathic Association ("AOA"), which sets out that "[a] doctor-patient relationship can only be established through at least one face-to-face meeting."[6] Additionally, guidance from the FSMB and AOA makes it clear that once the requisite face-to-face meeting has been held, practitioners should use electronic communications only as a way to supplement a physician-patient relationship, not as a means to replace it. Further, providers who wish to use telemedicine practices, such as communicating with patients through email or using online Personal Health Records ("PHR")

[5] Available online at: http://www.fsmb.org/pdf/2002_grpol_Use_of_Internet.pdf
[6] AOA Draft Policy Statement – Online Medicine, Res. No. H-281- A/2009 (July 17, 2009), available online at http://www.do-online.org/pdf/cal_hod09res281.pdf [hereinafter AOA Statement].

vendors such as Google Health or HealthVault, should establish clear rules and guidelines with their patients prior to the use of such technologies.

For example, the FSMB and American Medical Association ("AMA") have both issued proposed guidelines for the use of provider-patient email. These recommendations include:

- Establishing the types of transactions (prescription refill, appointment scheduling, etc.) and the sensitivity of the subject matter (HIV, pregnancy test results, etc.) permitted over email.
- Explaining that matters requiring lengthy or prolonged correspondence may need to be addressed in-person.
- Making sure patients understand privacy issues, including the identity of the person who will be receiving/reading the messages.
- Setting a turnaround time for messages.
- Making sure email messages are accompanied by "read receipt" requests.

See FSMB *Model Guidelines for the Appropriate Use of the Internet in Medical Practice*, *supra*; *see also* AMA Guidelines for Physician-Patient Electronic Communications[7].

Thus, practitioners should maintain written policies and procedures governing the use of patient-physician electronic mail and should require patients to sign agreements acknowledging and agreeing to abide by such guidelines. Practitioners should also be reminded that email and Internet correspondence must adhere to usual Health Insurance Portability and Accountability Act (HIPAA) regulations and other state/federal privacy laws.

IN MICHIGAN: The E-Health Workgroup's 2008 Report specifically recommended that the Michigan Department of Community Health adopt the FSMB's *Model Guidelines for the*

[7] Available online at: http://www.ama-assn.org/resources/doc/code-medical-ethics/5026a.pdf

Appropriate Use of the Internet in Medical Practice and communicate the guidelines to all licensed health care providers through Department websites and other communications channels. However, to date the MDCH has not adopted the FSMB guidelines. Additionally, the individual licensing boards (e.g., Board of Medicine, Board of Nursing, etc.; collectively, the "Licensing Boards") have not issued any formal guidance to their licensees in terms of when telemedicine may be used and appropriate protocols for doing so.

In Michigan, "telemedicine" is defined by statute as "the use of an electronic media to link patients with health care professionals in different locations."[8] However, there are no Michigan statutes or administrative rules addressing the issues of patient-provider relationships, confidentiality, or privacy in the context of telemedicine alone. That said, given the level of discussion on the topic in the respective Licensing Boards, as well as the E-Health Workgroup's recommendations, it is anticipated that laws in this regard will be forthcoming and this article will be supplemented accordingly.

In the absence of clear guidance from the MDCH, Bureau of Health Professionals, or individual Licensing Boards, Michigan health care providers should proceed with caution when using email or EHR technologies to communicate with patients. As will be discussed in more detail below, Michigan law has eliminated the "face-to-face" requirement as a condition of receiving payment from private insurers for health care services. A safe recommendation to clients would be to establish a face-to-face physician patient relationship under the traditional model prior to engaging in any telemedicine; to consult guidelines issued by the Professional Organization governing the practitioner's discipline (e.g., the AMA for medical doctors; the AOA for osteopathic doctors; the APA for psychologists, etc.); to abide by the FSMB, AMA, or

[8] *See* 2012 Mich. Pub. Act No. 214 (effective June 28, 2012); 2012 Mich. Pub. Act. No. 215 (Effective June 28, 2012).

AOA guidelines (unless more specific guidelines have been issued by the practitioner's own Professional Organization) whenever they correspond with patients by email or other online communication; and to make sure that all telemedicine policies are clearly explained to patients in advance.

E-PRESCRIBING

IN GENERAL: E-prescribing is simply the use of automated data entry systems to generate a prescription, rather than generating it on paper, and relying on automated/electronic methods of transmission of that prescription to the dispensing pharmacy. The tremendous benefits of e-prescribing are widely accepted in the healthcare community. On the quality end of the spectrum, the benefits include enhanced efficiency, patient safety, patient satisfaction, medication compliance, and formulary adherence. On the cost end of the spectrum, there are significant cost savings to both patients and providers. Patients save through automated identification of generic alternatives and avoid costly treatments to correct medication or drug interaction errors. Providers save by reducing the potential of medical malpractice exposure as a result of errors and by spending less time writing and communicating with pharmacists clarifying prescriptions (which is estimated will cost $414 billion in administrative costs by 2014). Given the foregoing, e-prescribing is here to stay.

In order to understand the legal environment necessary to both support and regulate e-prescribing, it is important to recognize that there are typically two parties or sites to an e-prescribing relationship: the prescribing-based site (i.e., the provider that generates the electronic script; hereinafter the "provider") and the pharmacy-based site (i.e., the pharmacy that dispenses the script, hereinafter the "pharmacy"). However, because the advent of technology and e-prescribing has resulted in the proliferation of unethical Internet and mail order

pharmacies, e-prescribing discussions and calls for regulation tend to focus around the pharmacy-end of that relationship.

As previously discussed, a prescribing-based site or provider which offers prescribing services based on completion of an on-line health history alone does not have the requisite physician-patient relationship to ethically or lawfully prescribe for the patient. However, except as otherwise noted in this section, the law typically does not impose additional requirements on the prescribing providers as long as the provider otherwise meets the legal requirements for telemedicine previously outlined in this paper (such as establishing a face-to-face relationship with the patient prior to engaging in telemedicine, including e-prescribing; having proper licensure; and complying with the applicable privacy and security rules, among other requirements).

IN MICHIGAN: Michigan has been at the forefront of the e-prescribing revolution, along with nine other states. In 2006, Michigan was recognized for its work in improving patient safety in the drug prescription process with its use of electronic prescribing technology. Indeed, largely as a result of a number of private collaborative projects between major health systems, employers, and health insurance organizations in Michigan, the State was ranked 6th in the nation for the number of prescriptions routed electronically in 2007 (moving up from number 10 in 2006).[9] That said, a firm legal framework for e-prescribing is yet to be implemented in Michigan and many recommended laws for dealing with e-prescribing issues are yet to be adopted.

Many of the legislative proposals currently pending in the Michigan Legislature had their genesis in a 2001 Report issued by the Michigan Department of Consumer & Industry Services Bureau of Health Services Task Force on Internet Pharmacies and Prescribing (the "Task

[9] *2008 Report, supra* note 1, at 20.

Force"). In that report, relying in large part on the work of the National Association of Boards of Pharmacies ("NABP"), the Task Force formulated six areas that needed to be addressed by the Public Health Code in order to properly support and regulate e-prescribing in the State.

Specifically, the Task Force called for (1) amendments to the pharmacy-related definitions to address e-prescribing and the advent of Internet pharmacy practices; (2) delineation of the nature of the provider-patient relationship with an emphasis on verification on the identity of prescribers and patients; (3) adoption of standards for identifying legitimate Internet pharmacies doing business under the appropriate regulatory umbrellas; (4) elimination of restrictions on mail order pharmacies; (5) establishment of licensure requirements for Internet and mail order pharmacies; and (6) addressing confidentiality requirements.[10] Unfortunately, though the Task Force recommendations triggered some administrate rule changes in the Board of Pharmacy General Rules,[11] the recommendations did not culminate in any legislative enactments or amendments to the Public Health Code. Thus, currently e-prescribing remains largely obstructed and yet unregulated in Michigan.

As far as the obstructions are concerned, the Public Health Code (the "Code") currently contains a number of impediments for e-prescribing in Michigan, all of which were targeted for correction by the Task Force to no avail, as follows:

- The definition of "license" does not recognize out-of-state pharmacies (Internet and mail order pharmacies) as entities that can be licensed in Michigan. Unlicensed out-of-state pharmacies may not do business in Michigan. *See* M.C.L. §333.7333; M.C.L. §333.17743; M.C.L. §333.17748.

[10] *Id*.
[11] Available online at: http://www7.dleg.state.mi.us/orr/Files%5CAdminCode%5C1102_2012-095LR_AdminCode.pdf

- Out-of-state pharmacies may not dispense Schedule II prescriptions without using an official prescription form, which currently is not available to them. *See* M.C.L. §333.7333.
- Pharmacies in Michigan may not dispense a prescription for a controlled substance that is written and signed by a physician prescriber who is licensed to practice in a state other than Michigan, making it impossible for Michigan Pharmacies to have equal access to the mail order industry. *See* M.C.L. §333.7405; M.C.L. §333.17763.
- Electronic transmission of a prescription is not recognized as "equivalent record of an original prescription," which causes compliance problems for in-state and out-of-state Internet and mail order pharmacies. *See* M.C.L. §333.17751.

Notwithstanding the lack of legislative action, Michigan does appear to be on the verge of taking some action to regulate the *websites* of pharmacies doing business in Michigan in an effort to differentiate them from arguably illegitimate Internet and mail order pharmacies with a web presence. Specifically, relying on the NABP's certification criteria for pharmacy websites known as the "Verified Internet Pharmacy Practice Sites" or "VIPPS," the Task Force has agreed to adopt the principles outlined by VIPPS as a guide in establishing new regulations in Michigan.[12]

The work of the Task Force also recently spun the formation of the Michigan Workgroup to further examine e-prescribing in the broader context of e-health and to encourage the implementation of the Task Force corrections and recommendations. When additional work

[12] Current VIPPS certification criteria available online at: http://www.nabp.net/programs/accreditation/vipps/vipps-criteria/

product by the Internet Task Force, the Michigan Workgroup, or any other legislative initiative in this area takes place, this paper will be updated to reflect the changes.

PRIVACY CONSIDERATION OF E-PRESCRIBING: The confidentiality of health information is protected by the federal Health Insurance Portability and Accountability Act (HIPAA), which governs the use and disclosure of health information by individuals and entities identified as "health care providers." Under the definition of "health care providers," pharmacies are specifically identified as one of the categories of providers having to comply with the requirements of HIPAA. HIPAA contains comprehensive standards for privacy and security that must be followed by entities engaged in e-prescribing, but those standards are outside of the scope of this paper.

INTRASTATE PRACTICE GUIDELINES/SPECIAL PURPOSE LICENSES

IN GENERAL: It is technologically feasible for a Michigan-licensed psychiatrist with an office in Kalamazoo to provide telepsychiatry to a patient in Temperance. However, what if the patient moves to Toledo? Or Texas? Since one of the underlying goals of telemedicine is to allow practitioners to provide "remote" treatment through electronic consultations, state boundary and licensing issues are certain to arise.

Generally speaking, most state medical boards take the position that the practice of medicine occurs in the state <u>where the patient is located</u>. Therefore, with respect to the above example, even though the physician is physically located in his office in Michigan, the fact that the patient is physically located in Toledo means that the practitioner is now practicing medicine in Ohio.

In response to this telemedicine obstacle, in 1996 the FSMB endorsed model legislation ("A Model Act to Regulate the Practice of Medicine Across State Lines,")[13] which, if passed by the individual states, would create a "special purpose license" enabling a physician to practice medicine across state lines. (The model legislation would need to be adopted by each state, since the FSMB acknowledged that a national license would be virtually impossible to police.)

In a nutshell, the special purpose license would allow physicians holding full and unrestricted (home) state licenses to practice medicine in any state. The special purpose license would carry reduced price, examination, and credentialing requirements. Currently, only ten states[14] have enacted some version of the FSMB model. The scope of telemedicine licensure varies by state. For example, Alabama law provides for an actual special purpose license to practice medicine across state lines.[15] In contrast, under Minnesota law, a physician does not obtain an actual "license," but may practice medicine across state lines so long as the physician is licensed without restriction in the state in which telemedicine will be provided, registers annually with the Minnesota Board of Medicine, and pays a registration fee.[16]

Similarly, the National Council of State Boards of Nursing has established a multi-state nurse license model referred to as the Nurse Licensure Compact ("NCL"), which allows a nurse to practice across state lines unless otherwise restricted. In order for a state to participate in the Nurse Licensure Compact, it must enact legislation or regulations recognizing the NLC and must also adopt administrative rules and regulations for the implementation of the compact. Therefore, a nurse licensed in a state participating in the NLC may practice nursing both

[13] Available online at http://www.fsmb.org/pdf/1996_grpol_Telemedicine.pdf
[14] Alabama, California, Minnesota, Montana, Nevada, New Mexico, Ohio, Oregon, Tennessee, and Texas.
[15] Ala. Admin. Code r. 540-X-16 *et seq*.
[16] Minn. Stat. §147.032

physically and electronically in other NLC-participating states. To date, 24 states have adopted the compact.[17]

MICHIGAN: The E-Health Workgroup has recommended that Michigan implement a special purpose license for all health care professionals regulated under Article 15 of the Michigan Public Health Code[18] who provide health care services or consultation via telemedicine across state lines to Michigan patients. The special purpose license would permit practitioners in regulated professions in other states to treat patients in Michigan via telemedicine. However, Michigan practitioners who wish to practice in other states would still be required to be licensed by the corresponding jurisdiction.

To date, no such special purpose license has been enacted. Additionally, the Michigan Physician Licensure statute does not currently provide for the practice of telemedicine across state lines. Michigan law provides that in order to be covered by private insurance, telemedicine services must be provided by a health care professional who is "licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located".[19] Therefore, out-of-state practitioners who intend to treat patients located in Michigan via telemedicine must be licensed in Michigan to do so. Additionally, Michigan practitioners may not treat out-of-state patients – even if the patient usually resides in Michigan. For example, even if a Michigan physician has a long-standing relationship with a patient, if that patient was

[17] These states include Arizona, Arkansas, Colorado, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, South Carolina, South Dakota, Rhode Island, Tennessee, Texas, Utah, Virginia, and Wisconsin. (Source: National Council of State Boards of Nursing website, available online at: https://www.ncsbn.org/ncl.htm)

[18] This list includes the following professions: chiropractic; dentistry; audiology; marriage and family therapy; medicine; nursing; optometry; osteopathic medicine and surgery; speech-language pathology; pharmacy practice and drug control; physical therapy; athletic training; massage therapy; podiatric medicine and surgery; counseling; psychology; occupational therapists; dietics and nutrition; sanitarians; social work; respiratory care; and veterinary medicine.

[19] *See* note 8, *supra*.

vacationing in Florida he could not be treated by the Michigan physician via telemedicine. Finally, Michigan does not currently participate with the Nurse Licensure Compact.

In sum, at the present time, persons interested in practicing telemedicine across state lines must be licensed in the state in which the patient is located. Practitioners should contact the applicable state licensing board to determine if full licensure is required, or if the state offers a special purpose license and/or otherwise accommodates out-of-state practitioners.

REIMBURSEMENT

IN GENERAL: In addition to the above-mentioned issues, any practitioner considering the use of telemedicine will undoubtedly want to know if he or she will be reimbursed for such services. While government-funded health care programs and some private payors do provide reimbursement for certain telemedicine services, practitioners should be aware of the criteria to qualify for such payments.

Medicare – First, a brief overview of the history of telemedicine coverage is instructive. Initially, the federal Balanced Budget Act of 1997 first allowed Medicare payments for online medical consultations for patients in rural areas. However, the legislation contained many barriers to coverage, such as limiting reimbursement to specific rural health professional shortage areas, and allowing only certain CPT codes to be billed. (Not surprisingly, although the Centers for Medicare and Medicaid Services predicted between $60 million and $690 million in telemedicine provider reimbursement following passage of the Balanced Budget Act, only $20 million was actually reimbursed.)

The scope of telemedicine coverage expanded gradually over the years, beginning with the Benefits Improvement and Protection Act of 2001, which (among other things) established a $20 originating site facility fee, expanded CPT codes eligible for billing, and also broadened the

geographic locations where services would be provided. Additionally, the 2008 Medicare Improvements for Patients and Providers Act added certain entities to the list of qualifying "originating sites" for the payment of telemedicine services.

Despite these developments, currently neither Medicare nor Michigan Medicaid (discussed below) reimburse for the type of "telemedicine" that is commonly envisioned – i.e., a patient receiving health care services long-distance from his or her home. Specifically, in order for telemedicine services to be reimbursed by Medicare, the patient receiving the services must be located at one of the following "originating sites:"

- The office of a physician or practitioner
- A hospital
- Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)
- A Federally Qualified Health Center (FQHC)
- A hospital-based or critical access hospital-based renal dialysis center (including satellites – however, independent renal dialysis facilities are not eligible originating sites)
- A Skilled Nursing Facility (SNF)
- A Community Mental Health Center (CMHC)

Additionally, the "originating site" must be located in either a rural health professional shortage area or a county not classified as a metropolitan statistical area.[20] (Note that certain entities who participate in HHS-approved telemedicine demonstration projects qualify as originating sites regardless of geographic location.) Thus, providers should discern if the originating site is eligible for telemedicine coverage prior to providing services.

[20] A "Metropolitan Statistical Area" (MSA) is defined by the United States Office of Management and Budget as having at least one city with a population of 50,000 or more, and having adjacent communities that share similar economic and social characteristics. The total population of an MSA is at least 100,000.

Additionally, Medicare currently provides reimbursement for professional consultations, office visits, office psychiatry services, and a limited number of other Part B physician fee schedule services. However, the services must be provided using interactive audio and video telecommunications, which permit real-time communication between the patient at the originating site and the practitioner at the distant site. Therefore, reimbursement for the use of "store and forward technologies" (e.g; where one practitioner conducts a taped medical/oral history exam with a patient and forwards to another physician for consultation or email) is not permitted.[21]

Moreover, in order to be reimbursable by Medicare, telemedicine services must adhere to all of the foregoing criteria and must be provided by one of the following practitioners (subject to the requirements of state law):

- Physician
- Nurse practitioner, nurse midwife or clinical nurse specialist
- Physician assistant
- Registered dietitian or nutrition professional
- Clinical psychologist or clinical social worker (note that clinical psychologist and social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare)

Medicaid/Private Payors – Additionally, many states have enacted state telemedicine/telehealth reimbursement laws pertaining to individual state Medicaid programs. To date, 39 states have passed state telemedicine/telehealth reimbursement laws or legislation impacting reimbursement for telemedicine and telehealth. While most state laws involve public

[21] Medicare payment is permitted for "store and forward" telemedicine only for federal telemedicine demonstration programs conduced in Alaska or Hawaii.

(Medicaid) funding, 15 states have enacted legislation specifically dealing with private payer reimbursement for telemedicine.[22] For example, Texas law mandates that a "health benefit plan [as defined by statute] may not exclude a telemedicine medical service or a telehealth service from coverage under the plan solely because the service is not provided through a face-to-face consultation."[23]

Such laws are endorsed by medical societies such as the AMA and AOA, which have both passed resolutions encouraging states to support the reimbursement of telemedicine services by private insurance.[24]

MICHIGAN:

Medicare – Michigan providers who participate with Medicare are bound by the above-listed guidelines to qualify for Medicare reimbursements. The specific details with respect to billing for telemedicine can be found in Chapter 15, §270 of the Medicare Benefit Policy Manual,[25] and Chapter 12, §190 of the Medicare Claims Processing Manual.[26]

One final consideration for Michigan providers with respect to Medicare payment is that, as a condition of Medicare Part B payment, "the physician or practitioner at the distant site must be licensed to provide the service under State law

Medicaid – In 2006, the agency responsible for the Michigan Medicaid program, the Michigan Department of Community Health ("MDCH") issued a bulletin[27] (MSA 06-22)

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[22] These states include California, Colorado, Georgia, Hawaii, Kentucky, Louisiana, Maine, Maryland, Michigan, New Hampshire, Oklahoma, Oregon, Texas, Vermont, Virginia. However, note that Colorado's statute only applies to patients in rural areas. (Source: Center for Telehealth and E-Health Law,http://ctel.org/2012/07/michigan-becomes-15th-state-to-pass-private-payer-telehealth-reimbursement/))

[23] Tex. Ins. Code Ann. §1455.001

[24] *See* AOA Statement, *supra* note 6; Resolutions by the AMA House of Delegates, House Action 123 (June 2007)(available online at: http://www.ama-assn.org/ama1/pub/upload/mm/38/a07res.pdf)

[25] Available online at: http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

[26] Available online at: http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf

[27] Bulletin available online at http://www.michigan.gov/documents/MSA_06-22_155090_7.pdf

regarding Medicaid reimbursement for telemedicine services that has been largely unchanged since then. The bulletin, in conjunction with the Michigan Medicaid Provider Manual[28], sets out the requirements for reimbursement for telemedicine services.

Pursuant to the Michigan Medicaid Provider Manual, the following services may be provided via telemedicine:

- Consultation
- Office visits
- Individual psychotherapy
- Pharmacological management
- End stage renal disease (ESRD) related services

The MDHC Telemedicine Services Database lists the specific procedure codes that may be billed for telemedicine services.[29]

As with Medicare rules, the "originating site" is the location of the eligible beneficiary (the patient) at the time the service being furnished via a telecommunications system occurs. The location of the physician or practitioner providing the telemedicine services is called the "distant site." Importantly, the distant site and the originating site must be at least 50 miles apart.[30] Additionally, in order for telemedicine services to be reimbursed, the patient must be at one of the following originating sites:

- County mental health clinic or publicly funded mental health facility
- Federally Qualified Health Center (FQHC)
- Hospital – either inpatient, outpatient, or a critical access hospital (CAH)

[28] Available online at: http://www.michigan.gov/mdch/0,1607,7-132--87572--,00.html
[29] http://www.michigan.gov/documents/mdch/Telemedicine_-_January_2011_Final_341335_7.pdf
[30] Michigan Medicaid Provider Manual, Practitioner Chapter, Section 20.1.

- Office of a physician or other practitioner (this includes medical clinics)
- Rural dialysis facility
- Rural Health Clinic (RHC)
- Skilled Nursing Facility (SNF)
- Tribal Health Center (THC)

Although, as always, the services provided must be medically necessary in order to be reimbursed, the decision of medical necessity will be made by the practitioner at the distant site. A medical professional is not required to "present" the patient to the practitioner at the distant site. Thus, a receptionist or office staff member could set the patient up with the telecommunications equipment. However, Michigan Medicaid requires that the examination of the beneficiary must be performed via a real-time interactive audio **and** video telecommunications system. That means that the beneficiary must be able to see and interact with the off-site practitioner.

Private Payors – Effective June of 2012, two laws in Michigan require private health insurers, including Blue Cross Blue Shield, to provide coverage for services "appropriately provided" through telemedicine. Essentially, the law limited the requirement of "face-to-face" contact as a perquisite for reimbursement. Now, telemedicine services may be covered, subject to the following conditions:

- For purposes of the law authoring coverage, to be considered "telemedicine" the law provides that "the health care professional must be able to examine the patient via a real time, interactive audio or video, or both, telecommunications system and the patient must be able to interact with the off-site health care professional at the time the services are provided."

- The services must be provided by a "health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located.
- Telemedicine services are subject to all terms and conditions between the insurer and the insured, including (but not limited to) co-payments, co-insurances, deductibles, and approved amounts.

SPECIAL ISSUES - MENTAL HEALTH

As discussed above, government payors will not reimburse for telemedicine services provided to patients in their home or via "forward and store" technologies, such as email. However, such restrictions have not impeded one growing area of telemedicine, which is Internet counseling. A wide range of telemedicine services related to mental and behavioral health has emerged in the past fifteen years, including online services offered by support groups and professional advocacy organizations; one-on-one interactive counseling sessions between therapists and patients; and telemonitoring devices for depression patients and other mental illness sufferers in order to support self-help, prevent suicide, and avoid re-hospitalization. In fact, the E-Health Workgroup has predicted that "virtual offices" are slated to become an integral part of the future of psychology practice, "including routine online video-therapy, or telemental, between practitioner and patient via computer, cell phone, or some other future technology."[31]

Importantly, since mental health services are often ranked second in priority to "physical" health services, telemedicine can be used to address the shortage of psychiatrists and other counselors. For example, at the Mott Children's Health Center in Flint, pediatric patients often have to wait two months to see the one child psychiatrist on staff.[32] In order to address this

[31] *2008 Report*, *supra* note 1, at 24.
[32] *See* Satyanarayana, *supra* note 2.

shortage, the hospital teamed with a special child psychiatry program at Michigan State University, where patients interact with physicians with the use of teleconferencing.[33]

Despite the opportunities presented by the use of "telemental" services and corresponding potential growth, there has been limited guidance issued by mental health professional societies. The American Psychological Association (APA) issued the "APA Statement on Services by Telephone, Teleconferencing, and Internet" in 1997, which simply deferred to previously-issued APA standards that recommend a psychologist 1) take reasonable steps to protect patients, clients, and research recipients from harm; 2) obtain informed consent; 3) assure confidentiality; 4) honor patient boundaries; 5) avoid harm; 6) describe the nature and expected results of therapeutic intervention; and 7) follow standards for proper advertising.[34]

While the American Psychiatric Association has offered guidance with respect to the specific technologies that should be used during telepsychiatry sessions[35] in a 1998 "Telepsychiatry Via Videoconferencing Resource Document," technology has undoubtedly advanced dramatically since then rendering the specific recommendations in terms of equipment, bandwidth, etc., no longer applicable. Importantly, however, the Resource document offers general guidance on clinical interview techniques; privacy, confidentiality, and informed consent; and maintaining medical records, which continue to be relevant guidance for mental health professional. For example, the Resource provides some analysis of when telepsychiatry may or may not be appropriate (in emergency situations, for forensic uses, etc.) and the advised content of medical records and progress notes for telepsychiatry sessions.

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[33] *Id*.
[34] Available online at: http://www.apa.org/ethics/education/telephone-statement.aspx
[35] *See* "Telepsychiatry Via Videoconferencing Resource Document," approved by APA Board of Trustees July 1998 (APA Document Reference No. 980021) (available online at: http://www.telepsychiatry.com/apa.pdf)

The National Board of Certified Counselors also published brief statements on Internet-related ethics in 2000. This policy statement addresses the definition and types of technology-assisted counseling, standards for ethical practice of internet counseling, and issues of confidentiality, licensure, and certification.[36] Additionally, the National Association of Social Workers, in Collaboration with the Association of Social Work Boards, released a 2005 handbook on issues pertaining to the use of technology and the practice of social work. The NASW/ASWB Handbook employs ten "standards" for practitioners to follow, such as adhering to the same protocols used in a face-to-face relationship; maintaining competency in the types of technologies used; and being cognizant of the advantages/disadvantages of online relationships.[37]

The E-Health Workgroup's *2008 Report* predicts that more detailed guidance on the technical, regulatory and financial issues of providing "telemental" services will be forthcoming.[38] In the interim, providers should follow the current guidance from their corresponding professional associations and keep in mind the payment limitation on "in-home" services – i.e., they are not currently reimbursable by Medicare or Medicaid.

Conclusion

Michigan practitioners who wish to experiment with the use of telemedicine must do so carefully and are well-advised to give consideration to guidance from national medical societies and health associations. (Currently, such guidance is mainly limited to physician providers – i.e. medical doctors or doctors of osteopathy – and nurses). In sum, although this article will be

[36] National Board for Certified Counselors, Inc. and Center for Credentialing and Education, Inc., *The Practice of Internet Counseling* (2000) (available online at: http://www.nbcc.org/assets/ethics/internetcounseling.pdf)
[37] National Association of Social Workers & Association of Social Work Boards, *NASW & ASWB Standards for Technology and Social Work Practice* (2005) (available online at: http://www.socialworkers.org/practice/standards/NASWTechnologyStandards.pdf
[38] *See* 2008 Report, *supra* note 1, at 25.

updated as specific guidance from the Michigan Bureau of Health Professionals, licensing boards, and/or specific statutory/administrative rules becomes available, attorneys should check on up-to-the-minute developments in the State prior to giving definitive advice on telemedicine issues.