OFFICE BASED SURGERY

Moderator: Patrick White, Attorney
Panelists: Destry Nelson, MBA Insurance Broker
Jeannette Domask, CPCU, RPLU Claims & Risk
Kelly Roy, MD, OB/GYN physician
Lynda Peterman, MD, Anesthesiologist
OBJECTIVES

• History
• Rules & Statutes (MD, DO and ASCs)
• Licensing-OBS versus ACS
• Benefits
• Potential Risks
• Actual Claims
• Cases in the Media
• Trends
First Ambulatory Surgery Center/Outpatient Surgery Center was established in AZ in 1970
1988 there were 1,000 ASCs
More than 3500 types of procedures can be performed in surgery centers
300 people are seen in a surgery center for every one person in a hospital
Most common: Pain Mgt, OB/GYN, Plastics, GI
• Peter Norman, MD
  – Three patients died under his care
  – All plastic procedures
  – Assisted by unlicensed personnel
  – Inadequate intubation
  – Convicted of murder and manslaughter-25 years
OFFICE BASED SURGERY

Physician offices
AZ Rev. Stat., Sec. 36-402(3)
Dept. of Health Services, Div. of Assurance and Licensure Services

- Physician offices and clinics are exempt from the licensing requirements applicable to health care institutions unless patients are kept overnight as bed patients or treated otherwise under general anesthesia.
• AZ MD Board adopted office based surgery rules effective 1/8/08
  AZ Administrative Code Title 4 Chapter 16 Article 7 R4-16-701 through R4-16-707

• AZ DO Board adopted office based surgery rules effective 11/8/14
  AZ Administrative Code Title 4 Chapter 22 Article 5 R4-22-501 through R4-22-508

• For Ambulatory Surgery Centers- Department of Health Services-Health Care Institutions: Licensing
  AZ Administrative Code Title 9 Chapter 10 Article 9 R9-10-901 thru R9-10-925
• The Three Federal Regulatory Organizations that offer accreditation:
  – Joint Commission on Accreditation of healthcare organizations (JCAHO)
  – Accreditation Association for Ambulatory Healthcare (AAAHC)
  – American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
RULE HIGHLIGHTS

• Policies and procedure
• Staff adequately trained and licensed
• Equipment standards
• Consent
• Compliance with fire codes, building codes, biohazard waste and controlled drug, supply and storage standards
• Sedation monitoring standards
• Patient Discharge
• Emergency policy and transfer protocol
OPINION: MODERATE SEDATION/ANALGESIA FOR DIAGNOSTIC AND THERAPEUTIC PROCEDURES Within the Scope of Practice of: RN

ADVISORY OPINION MODERATE SEDATION/ANALGESIA

- It is within the Scope of Practice of a Registered Nurse (RN) to administer medications to provide moderate sedation/analgesia for the purposes of diagnostic or therapeutic procedures.

- Moderate Sedation/Analgesia (“conscious sedation”) is defined as “a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Centers for Medicare and Medicaid Services (CMS) consistent with American Society of Anesthesiologist (ASA) guidelines, does not define moderate or conscious sedation as anesthesia” (CMS, 2011).

- It should be noted that sedation exists along a continuum, and RNs who administer moderate sedation/analgesia must be qualified to provide rescue support to patients who proceed to a deeper level of sedation.
ASA Physical Status Classification System

- **ASA I**
  A normal healthy patient
  Healthy, non-smoking, no or minimal alcohol use

- **ASA II**
  A patient with mild systemic disease
  Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity ($30 < \text{BMI} < 40$), well-controlled DM/HTN, mild lung disease

- **ASA III**
  A patient with severe systemic disease
  Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity ($\text{BMI} \geq 40$), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
PLUS

BENEFITS

• Quality
• Efficiency
• Convenience
• Reduce Costs
• Office space sharing
• Billing for providers
POTENTIAL RISKS

- Equipment/facility
- Scope of practice
- Selection criteria
- Discharge instructions
- 24 hour follow up
- Policies and Procedures
- Medical Assistant practicing outside scope
- Patient with sleep apnea unable to resuscitate
- Not practicing patient emergencies
- 24 hour f/u not properly documented or communicated
- Physician leaves before patient discharge and Anesthesiologist unable to respond to surgical emergency
• JOAN RIVERS
  – Endoscopy center for vocal cord paralysis
  – Allegations: improper consent; selfie taken with JR; failed to act when vital signs deteriorated

• VA Smartphone recording during procedure
  – Endoscopy center for colonoscopy
  – Allegations: defamation against Anesthesiologist and GI doctor; $500K judgment against Anesthesia
## TRENDS

### Cost Comparison:
**ASC v. Hospital Outpatient Department**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Patient Cost</th>
<th>Medicare Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ASC Co-pay</td>
<td>HOPD Co-pay</td>
</tr>
<tr>
<td>Cataract</td>
<td>$193</td>
<td>$490</td>
</tr>
<tr>
<td>Upper GI Endoscopy</td>
<td>$68</td>
<td>$139</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>$76</td>
<td>$186</td>
</tr>
</tbody>
</table>

ASCA Analysis of CMS Rates Effective 1 Jan. 2012

### Surgical Trends by Volume

- Inpatient
- Outpatient

Copyright © 2002 SMG Marketing Group Inc
Summary
we are almost there
REFERENCES

AZ had first ASC; retrieved from: http://www.ascassociation.org/aboutus/whatisanasc/history

Dr. Peter Norman-3 patient deaths; retrieved from:

AZ Med Board adopted office based surgery rules in Jan 2008; AZ Administrative Code Title 4 Chapter 16 Article 7 R4-16-701 through R4-16-707; effective 1/8/2008; retrieved from: http://apps.azsos.gov/public_services/Title_04/4-16.pdf


For Ambulatory Surgery Centers- Department of Health Services-Health Care Institutions: Licensing
AZ Administrative Code Title 9 Chapter 10 Article 9 R9-10-901 thru R9-10-925


ASC Accreditation; retrieved from: http://www.ascassociation.org/aboutus/relatedorganizations/accreditationorganizations

Joan Rivers death; retrieved from: http://www.vanityfair.com/style/2016/05/melissa-rivers-settlement-medical-malpractice-suit-joan-rivers-death

VA case; retrieved from: https://www.washingtonpost.com/local/anesthesiologist-trashes-sedated-patient-jury-orders-her-to-pay-500000/2015/06/23/cae05c00-18f3-11e5-ab92-c75ae6ab94b5_story.html

Arizona State Board of Nursing www.azbn.gov ; retrieved from: https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system

ASA classification, American Society of Anesthesiologists; retrieved from: https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system

ASCs reduce outpatient procedure costs by $38B per year compared to HOPDs: 5 insights; Written by Anuja Vaidya | June 14, 2016
Telemedicine Panel

Moderator-Mandi J. Karvis
Underwriter-Debra Goldberg
Claims-John Hastings
Provider-Michel Sucher, M.D.
Telemedicine

Statutes, claims issues, and risk considerations
Topic Overview

- History & Definition of Telemedicine
- Applicable Statutes
- Federation of State Medical Boards
- Interstate Licensure Compact
- Claims considerations
- Underwriting considerations
- Present use and likely future expansion
- Q & A
Applicable Statutes

- A.R.S. 36-3601 Definitions
- Telemedicine—means the practice of health care delivery via interactive audio, video, or data communications.
- Can be used for diagnosis, consultation and treatment and to transfer data.
• A.R.S. 36-3602 Delivery of health care through telemedicine; requirements, exceptions.
• Shall obtain verbal or written informed consent before telemedicine treatment.
• If the consent is verbal, the provider must document it in writing in the patient’s chart.
• Exceptions to the consent requirement.
• A.R.S. 36-3601 Use of telemedicine for abortion prohibited
• Shall not use telemedicine to provide an abortion.
• To do so, is a violation and is an act of unprofessional conduct subject to license suspension or revocation
• What is it?
• How is it involved in telemedicine?
• How many states are involved?
• 47 State Boards require that a physician engaging in telemedicine be licensed in the state in which the patient is located.
• 13 states issue a special purpose license for the provision of telemedicine.
Practice Guidelines

• ATA-American Telemedicine Association
• Practice Guidelines for Live, On Demand Primary and Urgent Care
• Practice Guidelines
• Technical Guidelines
• Administrative Guidelines
• Guidelines and the applicable standard of care
AZ joined in 2016 via HB 2502, which was signed by Governor Ducey on 5/11/16

What does that mean for physicians who want to practice telemedicine in AZ?

What does that mean for AZ physicians who want to provide telemedicine services in several states?
CLAIMS ISSUES

- Insured will be local, but the claim will likely be elsewhere.
- Unfamiliar venue which may have very different laws, jury pool etc.
- Monitoring a case in another state with out of state counsel.
• Identify local defense counsel to help navigate the unfamiliar system.
• Seek referrals through PLUS directory and other similar organizations.
• Interview potential defense counsel candidates to ensure they will fit into the scheme.
• Face to face meeting with local counsel.
• Consider retaining a TPA.
Risk Issues

- Special policy provisions
- Licensure considerations
- Credentialing & privileges
- Impact of litigation or board complaint (snowball effect)
Current Uses of Telemedicine

- Rural areas that lack specialty coverage
- Radiology, stroke etc.
- Out of state patients
Future of Telemedicine

- Likely to expand to other specialties, uses as technology improves and more States get on board.
Questions
The Role of Telemedicine in Healthcare Delivery

John Shufeldt MD, JD, MBA, FACEP
Chief Executive Officer
MeMD, Inc.
Scottsdale, AZ
Telemedicine vs Telehealth

• Slightly different definitions
  – Note definitions still in a state of flux
  – In general, telehealth is the favored term

• Telehealth (broader term)
  – Using electronic information/telecommunications technologies to support long-distance clinical health care, patient/professional health-related education, public health and health administration
  – Technologies: video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications
T/T Adoption Rate

- T/T can now be considered mainstream

Technology Adoption Curve
Estimate of T/T Adoption: Red Arrow

Change in On Demand Healthcare

Provider Centric:
- PRIMARY CARE

Hospital Centric:
- EMERGENCY DEPARTMENT

Retail Centric:
- URGENT CARE

Consumer Centric:
- RETAIL CLINICS
- CONCEIRGE MEDICINE
- TELEPHONIC CARE
- ONLINE CARE
T/T Service Providers

- National T/T service providers
  - MeMD, AmWell, Teladoc, MD Live, etc.
- Large health systems some with a regional and/or national presence
  - Mayo Clinic, Cleveland Clinic, etc.
- Local hospitals, health systems, group practices
- T/T provider numbers have grown exponentially in the past several years
PLS

Key Features of a T/T Provider

• Broad provider network for the regions that need service
• Rigorous credentialing/recredentialing of providers
  – Certification preferred (e.g., NCQA)
• Ensure board certification of providers
  – Examples: Emergency Medicine, Internal Medicine,
    Family Medicine, Pediatrics
Key Features of a T/T Provider

- Monitor and address, if necessary, medicolegal provider issues (e.g., lawsuits, healthcare board sanctions, etc.)
- Proper and adequate malpractice coverage for providers
- Quality assurance protocol to monitor provider performance and provide feedback
**PLUS**

Key Features of a T/T Provider

- Assure provider compliance with nationally recognized care guidelines
  - Example: Antibiotic stewardship to prevent antibiotic overuse
- Provide patient feedback mechanisms to maximize patient satisfaction
- Language translation services, if desired
PLoS  Key Features of a T/T Provider

- Cutting edge T/T software system
  - Care coordination: Patient guidance in system
  - Audio/phone only, audio + video
  - e-Prescription functionality
  - Camera, video, & sensor data integration
  - Ability to export data/reports to external EHR systems and other healthcare providers
  - Robust reporting capabilities to allow group client access to needed T/T data and reports
  - Easy compatibility with widely used consumer electronic devices
    - Windows, Mac, and Mobile (iPhone, iPad, Android)
Show T/T cost savings compared to live, in-person care models

<table>
<thead>
<tr>
<th>Redirection Costs</th>
<th>Cost*</th>
<th>Percentage of Visits</th>
<th>Weighted Average Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>$950.00</td>
<td>14%</td>
<td>$133.00</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$140.00</td>
<td>41%</td>
<td>$57.40</td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>$105.00</td>
<td>34%</td>
<td>$35.70</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>$125.00</td>
<td>8%</td>
<td>$10.00</td>
</tr>
<tr>
<td>Other</td>
<td>$0.00</td>
<td>3%</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

| T/T Visit Fee             | $35.00 |
|                          |        |

| Savings                   | $201.10 |

- Weighted average cost of an incremental visit = $236.10
- Savings calculated by redirecting one patient to T/T = $201.10
T/T Patient Encounter System

1. Patient in need of treatment
   - Enters secure T/T site
     - Completes patient history/paperwork
     - Completes payment information

2. Medical provider evaluates patient via phone or audio+video

3. Patient receives medical record and Care Instructions; Rx (if necessary) is sent electronically

4. Patient requires:
   - Clinic evaluation
   - Emergency Room evaluation

Patient requires Emergency Room evaluation
Where would you have gone if T/T were not available?

- 14% EMERGENCY DEPARTMENT
- 41% URGENT CARE
- 33% PRIMARY CARE PROVIDER
- 9% SPECIALTY CARE
- 3% OTHER

11.93% Plan Utilization

Top Treated Conditions

- Sinus Symptoms: 368 visits
- UTI: 145 visits
- Sore Throat: 42 visits
**In 2016, 15 million in the US will use T/T**

American Telemedicine Association

This number will grow to **160 million** by 2019.

**Almost 75% of all doctor, urgent care, and ER visits “are either unnecessary or could be handled safely and effectively over the phone or video”**

American Medical Association

**More than 187.5 million people in the U.S. own smartphones**

Accenture, May 2015

**68% increase in the number of employers offering telemedicine in 2015 (a rise from 22% to 37%)**

Towers Watson

**$6 Billion expected savings in healthcare costs**

**$140 average in-office visit cost**

**$40 average on-demand visit cost**

Major National T/T Providers
Low Acuity/Urgent Care

- Respiratory Infections
  - Upper Respiratory Infection (URI, head cold)
  - Bronchitis
  - Mild Pneumonia
- Sinusitis
- Urinary Tract Infection
  - Cystitis (bladder infection)
- Skin Problems
  - Hives (Poison ivy)
  - Other rashes
  - Mild burns
  - Mild scrapes, cuts (not requiring stitches)
- Mild bites and stings
- Mild abdominal conditions
  - Nausea, vomiting, diarrhea
- Mild sprains/strains
  - Wrist, ankle, neck, back
- Mild headache
- Seasonal allergies (e.g., hay fever)
- Conjunctivitis (aka pink eye)
- Ear infections
- Influenza (Flu)
Low Acuity/Urgent Care

- A small percentage, approximately 4-5% of low acuity patients are referred to live, in-person care
- Emergency room, Urgent or Primary Care
- Must be a protocol in the T/T system to safely refer out and follow up with these patients
Chronic Disease (CD) Management

- CD cause 70% of deaths in US
- CD leading US cause of death/disability
- CD 75% of US healthcare spending
- $8000 per CD patient annually
- CD patients lifetime healthcare costs 5X that of non CD patients
T/T and CD Management

- Significant evolving role for T/T
- Significant push from patients, caregivers, CMS, insurance companies, and large employee groups/companies
- Goal is to improve care quality and patient satisfaction and decrease management costs
- Management of high dollar conditions to improve outcomes and decrease spending
T/T and CD Management

- Diabetes mellitus
- Heart disease/Congestive heart failure
- Chronic obstructive pulmonary disease (COPD) such as asthma and emphysema
- Obstructive Sleep Apnea (OSA)
T/T and Diabetes Management

- Medication compliance & blood sugar control key to improve health/cost control
- Several WiFi and cellular network BS monitoring systems available
- Can be used in conjunction with T/T to better monitor these patients
- T/T can be used in conjunction with patient’s primary care provider
T/T and Diabetes Management

• Can expand the reach and scope of practice to 24/7 monitoring of these patients
• Preventing an episode of severe hyperglycemia or hypoglycemia + hospitalization can save tens of thousands of healthcare dollars per episode
T/T and Heart Disease

- T/T especially useful in the monitoring and management of chronic heart failure (CHF)
- CHF patients can deteriorate in a matter of days or even hours
- The window for outpatient intervention in an acute exacerbation is limited
- T/T can be especially useful during the night hours and weekends
- The EHR record can be available to the T/T provider allowing quick intervention
- This can prevent a hospitalization, which can save tens of thousands of dollars
COPD such as emphysema and asthma can deteriorate quickly. T/T monitoring allows for a quicker medical response to an exacerbation episode. This can prevent the need for live urgent care, primary care, emergency room visit, or even hospitalization. Tens of thousands of healthcare dollars can be saved.
Over 10% of the general population has obstructive sleep apnea (OSA).

OSA: Significantly under-diagnosed/treated.

OSA associated with significant long term health problems (heart dz, stroke, lung dz).

Traditional live sleep evaluations (eg, sleep studies in sleep centers) cost several thousand dollars.
There are several, high quality, smartphone like home sleep study units available.

These can be used in conjunction with T/T evaluation, diagnosis, and treatment of OSA.

The cost is 50-75% less than a live, sleep center evaluation.
T/T: Specialty & 2nd Opinions

- T/T is playing an ever increasing role regarding healthcare 2nd opinions
- It is also playing an increasing role in specialty consults (eg, neurology), especially larger health centers (eg, Mayo)
- Several states have passed specific laws (legislature) and/or regulations (medical board) governing this practice
Other T/T Applications

- Telemental Health and healthcare for rural/underserved areas
  - See section 4 of this presentation
- Telestroke
- Teledermatology
- Telerefraction (eye glasses, controversial)
Key T/T Hurdles & Limitations

- T/T protocol to deal with medical emergencies
- 50 states and 50 policies (plus D.C.)
- Healthcare licensure issues
- E-Prescription and controlled substances
- Provider-patient relationship definition
- Reimbursement: Private insurance parity, Medicaid, and Medicare
T/T: Medical Emergencies

- T/T providers and systems must have a strong protocol to deal with emergencies
  - Example: Patient tells T/T provider – Yes, I have a stuffy nose but by the way I am having severe, progressive chest pain, especially with exertion…

- Referral and follow up to emergency room, primary care, or urgent care must exist and be enforced

- 911 policy can be complex since a national clearinghouse for 911 services does not exist
• Some limited federal T/T legislation
• T/T legislation in 50 states and D.C.
• T/T regulations in 50 states (and D.C.) by medical, nursing, and pharmacy boards
• Tracking all of these “moving parts” is challenging, but required, of any T/T provider
• Current situation
  – The provider must be licensed in the state the patient is in when they receive the T/T care
  – If states allow a physician to perform T/T services, they generally allow the same for NPs and PAs (restrictions may apply)

• Special state T/T license or permit
  – These were once in vogue but for the most part are being phased out
• Federation of State Medical Boards (FSMB)

• FSMB Interstate Compact to Expedite Medical License (ie, the FSMB compact) 2013-present
  – Licensing option under which qualified physicians seeking to practice in multiple states would be eligible for expedited licensure in all compact states
  – Potentially well suited for T/T practice

http://www.fsmb.org/policy/advocacy-policy/interstate-model-proposed-medical-lic
PLUS T/T: Healthcare Licensure Issues

- FSMB Licensure Compact similar to the reciprocity nursing licensure structure
- Would potentially create a less onerous and expensive way for physicians to obtain T/T licenses in multiple states
- Actual process of expedited licensure to be announced soon and as always the devil will be in the details
Status as of 17 August 2016
http://licenseportability.org/
• As per the 50 states/50 policies discussion, every state (plus D.C.) has a T/T E-Prescription policy

• Non-controlled T/T drug prescriptions
  – Significant state variation from but the trend is toward leniency with regard to T/T

• A number of states do not differentiate prescription rules from live encounters
  – This number is steadily decreasing as states specifically address T/T issues
• Although many states have addressed T/T E-Prescription of controlled substances, all of these laws/regulations are subservient to a federal law on this issue

• Ryan Haight Act
  – **Ryan Haight** Online Pharmacy Consumer Protection Act of 2008
  – Key point: A controlled substance cannot be prescribed unless a provider with prescription power is **in the same room** as the patient

• Key controlled substance types include narcotics, benzodiazepines (eg, valium), and stimulants (eg, Ritalin)

• Significantly affects **telemental health**
A provider-patient relationship must be established before care can be rendered.

Almost all states allow this relationship to be established via T/T. Some allow phone only, others require audio + video.

A small number of states require that the patient to be seen live, in the past, by the provider wanting to provide T/T care.

Some states allow T/T evaluation for acute conditions, but require a live follow-up evaluation within a specific time period.

Some states allow T/T evals, but prescriptions require a live evaluation.

The trend over the past year is that almost all of these restrictions are being eliminated by states.
31 states + D.C. now have some form of reimbursement parity legislation

Parity requires equal private insurance reimbursement for T/T services

Much variation in the parity legislation
  – Only 23 states + D.C. mandate equal reimbursement for T/T compared to live
  – Other states limit the types of technology, patient location, covered provider types
  – Other states may require an in-person visit to establish a patient-provider relationship
States with Parity Laws for Private Insurance Coverage of Telemedicine (2016)

State T/T Parity Laws Map, July 2016: Courtesy of the American Telemedicine Association
T/T: Medicaid and Medicare

- Medicaid: Federally funded, state run, low income health coverage system
  - All 50 states + D.C. have a Medicaid T/T protocol either in force or under consideration
  - Significant state-to-state variation
  - 16 states cover remote patient monitoring
T/T: Medicaid and Medicare

• Medicare
  – Currently limited T/T coverage with provider and patient location limitations and geographic limitations (eg, rural)

• Significant Medicare T/T coverage changes coming over the next several years
  – Second generation ACOs have robust T/T mandates and funding
  – MACRA legislation strongly favors an expanded T/T role starting in 2017
T/T: Rural and Underserved Areas

- T/T significant advances to date in serving patients in rural and underserved areas

- Advantages
  - Less travel for patients for live, in-person care
  - Does not matter where the providers are located to provide care
  - Expands the reach and availability of primary care providers in these areas
  - More opportunity for specialty care and 2nd opinions formerly only available in metro areas
T/T: Rural and Underserved Areas

- Disadvantages
  - May still required significant patient travel to fill a prescription provided via T/T
  - May be care coordination issues with the patient’s primary care provider
  - Timely transfer of T/T record to the local provider and/or EHR system
  - Rural patient has to deal with an unfamiliar provider from a long distance away
Behavioral Health: Telemental Health

- Behavioral health, demographically, has been underserved for many decades – both urban and rural
- Telemental health holds huge promise to bridge this health services gap
- Telemental health (TMH) is a broad area
  - Expand the availability of a patient’s existing relationship with a mental health professional
  - TMH can be an adjunctive modality to complement live mental health therapy
  - TMH can also involve social workers who can assist mental health patients in many ways
  - TMH can also involve counseling (eg, college students with mild mental health issues)
PLUS Behavioral Health: Telemental Health

• TMH has unique differences compared to other T/T modalities
  – Evaluations tend to be longer (e.g., 45 minutes versus 10-15 minutes)
  – Larger variety of TMH professionals involved including psychiatrist, psychologists, social workers, and counselors
  – Better patient acceptance

• TMH professional credentialing tends to be more complex compared to other T/T modalities
On August 23, 2016, Arkansas’s medical board approved telemedicine as a way to establish a physician-patient relationship. This means that every medical board in the country now allows a physician-patient relationship to be established by utilizing real time audio and visual telemedicine technology as long as it would reveal the same amount of information as an in-person examination.
The CONNECT (Creating Opportunities Now for Necessary and Effective Care Technologies) for Health Act is the most recent bill introduced in Congress (Feb. 2016). It would expand telemedicine coverage and promote cost savings and quality care under the Medicare program through the use of telehealth and remote patient monitoring services.

This bill will likely be part of “must-pass” legislation in 2016.

Supporters of the bill project it could save Medicare as much as $2 billion over the next 10 years.
States blocking telemedicine - could run into issues with federal anti-trust laws as they try to regulate telemedicine.

5th Circuit Court of Appeals out of Texas

- Teledoc, Inc, is claiming that the Texas Medical Board is violating federal anti-trust laws because it passed a regulation that requires an in-person consultation prior to certain medications being prescribed.

Questions?