New Developments and Trends in Telemedicine and Telehealth

OSHRM/SOHA Conference September 25, 2015

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“We need to bring the exam room to where the patients are.”
Dr. Jay H. Sanders, “The Father of Telemedicine”

- Telehealth v. Telemedicine
- Ohio Law
- Reimbursement
- Licensure
- Credentialing
- Prescribing
- Consent
- Privacy and Security
- Antikickback Implications
- State Telemedicine Law Developments
- The Future
Telehealth Defined:

- Broader than telemedicine; **includes non-clinical services**
- The Health Resources Services Administration defines telehealth as the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration
- May include providing clinical services to patients at a distance, monitoring a patient’s vital signs from a distance, transmitting x-rays from a patient at a rural clinic to a radiologist in an urban hospital, broadcasting continuing education programs to physicians throughout the state
Telehealth v. Telemedicine

Telemedicine Defined:

- The American Telemedicine Association (ATA) defines telemedicine as “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 Federation of State Medical Boards (FSMB) defines the practice of telemedicine as the “practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening health care provider.”
Definition of Telehealth/Telemedicine by State

- **Kentucky:**
  - Telehealth consultation means a medical or health consultation, for purposes of patient diagnosis or treatment, that requires the use of advanced telecommunications technology, including, but not limited to: (a) compressed digital interactive video, audio, or data transmission; (b) clinical data transmission via computer imaging for teleradiology or telepathology; and (c) other technology that facilitates access to health care services or medical specialty expertise. KRS 205.510(15)

- **Indiana:**
  - Telemedicine services means a specific method of delivery of services, including medical exams and consultations and behavioral health evaluations and treatment, including those for substance abuse, using videoconferencing equipment to allow a provider to render an examination or other service to a patient at a distant location. The term does not include: (1) a telephone transmitter for transtelephonic monitoring or (2) a telephone or any other means of communication for the consultation from one provider to another provider. IN Code. 12-15-5-11

- **Pennsylvania:**
  - Telemedicine is the use of real-time interactive telecommunications technology that includes, at a minimum, audio and video equipment as a mode of delivering consultation services. *Pa. Dept. of Public Welfare, Medical Assistance Bulletin 09-12-31, 31-12-31, 33-12-30* (May 23, 2012)
Ohio Telemedicine Definition

- **Definitions:**
  - **Telemedicine Certificate Statute:** “The practice of telemedicine” means “the practice of medicine in this state through the use of any communication, including oral, written, or electronic communication, by a physician located outside of this state.” ORC 4731.296

- **Medicaid Program:** Telemedicine is the direct delivery of evaluation and management (E&M) or psychiatric services to a Medicaid eligible patient via synchronous, interactive, real-time electronic communication that comprises both audio and video elements. *OH Medicaid Handbook Transmittal Letter No. 3334-15-01. Jan. 2, 2015, pg. 6*
Traditional Modalities of Telehealth

- **Real-Time**
  - Live, two-way interaction between a patient and a health care provider using audiovisual technology

- **Store-and-Forward**
  - Transmission of a patient’s recorded health history through a secure electronic communication system to a health care provider

- **Remote Patient Monitoring**
  - Collection of a patient’s personal health and medical data via electronic communication technologies. Once collected, the data is transmitted to a provider at another location, with continual tracking by original provider

- **mHealth**
  - Wearable devices/smart phones to track health and wellness
  - Market expected to increase from $1.5 billion in 2014 to $6 billion by 2016
Benefits of Telemedicine

- **Improved Access**
  - Approximately 20% of Americans live in rural areas with limited access to primary care or specialist services

- **Cost Efficiencies**
  - 6 billion a year in health care savings to U.S. companies

- **Improved Quality of Care**
  - Better survival rates, reduced hospital lengths of stay, reduced hospital readmission

- **Patient Satisfaction**

  “Telehealth services in the VA post-cardiac arrest care program reduced hospital readmissions by 51% for heart failure and 44% for other illnesses.”
Telemedicine at Work: North Carolina Telepsychiatry Network

- 28 counties across NC do not have a psychiatrist, leading many people to seek treatment at local hospital
- 2014: NC General Assembly launched state-wide telepsychiatry system
- All hospitals in NC allowed to participate
- Specific findings as of March 2014:
  - Length of stay for patients in EDs waiting to be discharged to inpatient treatment declined from 48 hours to 22.5 hours
  - Number of involuntary commitments to local hospitals or state psychiatric hospitals decreased by 33%
  - 88% of patients agreed or strongly agreed that they were satisfied with telepsychiatry services they received
Barriers to Telemedicine

- Reimbursement
- Licensure
- Credentialing
- Prescribing
- Consent
- Privacy and Security
- Antikickback
- Patient willingness

“We now feel it’s cheaper to do surgery via Skype. So, go home and lie down in front of your computer.”
Medicare Reimbursement

Telehealth Services (42 CFR 410.78)
- Medicare Part B pays for services furnished by an interactive telecommunications system if:
  1. Practitioner at distant site is licensed to furnish the service under state law (includes physician extenders)
  2. The services are furnished to a beneficiary at a particular originating site (includes office of practitioner, CAH, rural hospital, FQHC, SNF, community mental health center)
  3. Originating site must be located in either a rural health professional shortage area or in a county not included in a Metropolitan Statistical Area
  4. Medical examination of the patient is under the control of the practitioner at the distant site
- Medicare does not reimburse for training or education and limits reimbursement to small set of enumerated services provided in rural areas
- **Interactive telecommunications system** means at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.
Medicare Reimbursement

- CMS’ 2015 physician payment fee schedule final rule added the following services to the telehealth list:
  - Psychoanalysis
  - Family psychotherapy
  - Prolonged evaluation and management services
- The ACA incentivizes Medicare-participating hospitals and other providers to test and implement various types of clinically integrated care models
- Congress created the Center for Medicare and Medicaid Innovation (CMMI) for testing “innovative payment and service delivery models to reduce program expenditures… while . . . enhancing the quality of care”
- Dec. 1 2014 proposed rule issued by CMS:
  - Requiring an ACO to describe in its application how it will encourage and promote telehealth services
Medicaid Reimbursement

- Reimbursement differs state by state
- States must satisfy the federal requirements of “efficiency, economy, and quality of care”
- Once state meets necessary federal requirements, the state may choose
  - whether to cover telemedicine services
  - types of services covered
  - locations within state the services may be provided
- “States are encouraged to use the flexibility inherent in federal law to create innovative payment methodologies for services that incorporate telemedicine technology” – Informal Guidance on Medicaid.gov website
As of May 2015, **27 states and DC** have enacted “parity” laws, which generally required health insurers to cover and pay for services provided via telehealth the same way they would for in-person services.

**Newest laws:**

- **Indiana**: requires coverage of telemedicine services under private insurance via interactive audio, video or other electronic media. The [new law](#) also prohibits a health care provider from being required to obtain a separate additional written health care consent for the provision of telemedicine services.

- **Minnesota**: requires health plans to cover and reimburse for telemedicine in the same manner and at the same rate as in-person services.

- **Nevada**: requires coverage and reimbursement for telehealth under private insurance, Medicaid and workers compensation to the same extent and in the same amount as though provided in person.
Parity Law - Ohio

- Senate Bill 32 introduced in 2015 to establish telehealth parity for:
  - Multiple payer welfare arrangement operating a group self-insurance program (ORC 1739.23)
  - Individual or group health insuring corporation policy (ORC 1751.691)
  - Individual or group policy of sickness and accident insurance (ORC 3923.235)
  - Medicaid (ORC 5111.026)

- Would prohibit the exclusion of coverage for a telemedicine service solely because service is not provided through a face-to-face encounter.
Anthem recently announced the LiveHealth Online Telemedicine Primary Care Video Consultation Program to Plan Enrollees:

1. Sign up
2. Choose a doctor
3. Start a session

- Patients can self-report health information so that doctors have access to patient medical history
- Typical doctor visit is 10 minutes
- Patients have to select the state they are in so that they see doctors licensed to treat in that state
- Follows state laws re: prescription
- No controlled substances
- Cost is $49 (unless health plan covers visits)
This September, UC Health launched a pilot program that will enable UC Health Plan enrollees who need urgent care to consult without paying a co-pay with doctors via a smart phone, tablet or desktop computer.

- Six month experiment
- Goals: making doctors more accessible, improving patient care, increasing efficiency and lowering costs
- Video exchanges encrypted via a software application to ensure patient privacy and compliance with federal law
- Each video visit expected to take less than 10 minutes
Licensure

- Historically, when a physician treats a patient, the physician is presumed to be licensed to practice medicine where the patient is located.
- Process to obtain licensure varies from state to state and is dictated by each state’s Medical Practice Act.
- States have enacted medical licensure laws carving out exceptions for telemedicine practice.
  - 8 state medical boards issue special licenses or certificates related to telehealth: AL, LA, NM, OH, OK, OR, TN, TX.
Licensure - FSMB Interstate Compact

- Federation of State Medical Boards (FSMB’s) Interstate Medical Licensure Compact
  - 11 states have adopted: AL, ID, IL, IA, MN, MT, NV, SD, UT, WV, WY
  - Allows for an Interstate Commission to form an expedited licensure process for licensed physicians to apply for licenses in other states
  - Participating state medical boards retain their licensing and disciplinary authority, but would agree to share information and processes essential to the licensing and regulation of physicians who cross state borders
  - Participation would be voluntary, for both states and physicians
CMS rules regarding health care provider credentialing and privileging:
   COP in Medicare, hospitals must require all Medicare practitioners undergo credentialing and privileging by each originating site.

On May 5, 2011, CMS revised its telemedicine credentialing policy in final rule CMS-32257-F:
   When telemedicine services are provided at a distant-site hospital, the hospital whose patients receive the services may choose “to have its medical staff rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians and practitioner providing such services” if:
   1. The distant-site hospital providing telemedicine services must be a Medicare-participating hospital;
   2. The distant-site practitioner providing telemedicine services must be privileged at the distant-site hospital providing telemedicine services;
   3. The distant-site practitioner held a license issued or recognized by the state in which the receiving hospital is located;
   4. The hospital whose patients are receiving telemedicine services must have evidence of an internal review of the practitioner’s performance; including info on adverse events and complaints
Credentialing and Privileges – TJC 2011 Revisions

Medical Staff (MS)

Standard MS.13.01.01
For originating sites only: Licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.

Element of Performance for MS.13.01.01

A 1. All licensed independent practitioners who are responsible for the patient’s care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms:

- 1. The originating site fully privileges and credentials the practitioner according to Standards MS.06.01.03 through MS.06.01.13.
  Or
- 2. The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited organization. The distant-site practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.
  Or
- 3. The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:

   1. The distant site is a Joint Commission–accredited hospital or ambulatory care organization.
   2. The practitioner is privileged at the distant site for those services to be provided at the originating site.
   3. For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of licensed independent practitioners’ privileges.
   4. The originating site has evidence of an internal review of the practitioner’s performance of these privileges and sends to the distant site information that is useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided, and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site. (See also LD.04.03.09, EP 9)

- The distant-site practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.
Prescribing

- Some states do not allow practitioners who have never physically examined a patient to prescribe medication.
- Most states consider using an internet/online questionnaire to establish a provider-patient relationship as inadequate.
- States may also require a physical examination be administered prior to prescribing; however, some allow the use of telehealth to conduct the exam.

**Kentucky:**
A “good faith prior examination” (needed to establish a physician-patient relationship) can be done through telehealth.
*KY Rev. Statute 218A.010*

**Arkansas:**
Without a prior and proper patient-provider relationship, providers are prohibited from issuing prescriptions solely in response to an Internet questionnaire, an Internet consult, or a telephone consult.
*AR Code Annotated Sec. 17-92-1003 (2012)*

**Alabama:**
Telehealth medical services provided at an established medical site may be used for all patient visits, including initial evaluations to establish a proper provider-patient relationship between a distant site provider and a patient.
*Al. Admin. Code 540-X-15-.09*
Prescribing - Ohio

**Current Ohio Law (OAC 4731-11-09):**

- A physician shall not prescribe, dispense, or provide any dangerous drug, which is not a controlled substance, to a person who the physician has never personally physically examined and diagnosed.

- Eligible exceptions:
  - The physician is providing care in consultation with another physician, who has an ongoing professional relationship with the patient, and who has agreed to supervise the patient’s use of the drug or drugs to be provided, and the physician’s care of the patient meets all applicable standards of care;
  - In institutional settings;
  - On-call situations;
  - Cross-coverage situations;
  - Situations involving new patients;
  - Protocol situations;
  - Situations involving nurses practicing in accordance with standard care arrangements.
State Medical Board of Ohio released an interpretive guideline of OAC Rule 4731-11-09 (September 2012)

- “with advances in medical technology it may be possible for the ‘personal’ and ‘physical’ examination . . . To occur when the provider and patient are located in remote locations.”
- Only applies to non-controlled substances
- When examining a patient at a remote location, the physician or authorized prescriber should obtain:
  - A reliable medical history and perform a physician examination of the patient, adequate to establish the diagnosis for which the drug is being prescribed and identify underlying conditions and/or contraindications
- Prior to initially prescribing:
  - Establish valid provider patient relationship; have appropriate diagnostic medical equipment capable of real-time transmission; sufficient dialogue with patient regarding treatment options/risks; follow-up with patient to assess therapeutic outcome; maintain medical record readily available to patient that includes electronic prescription information
Prescribing – ORC 4731.74 (Am. Sub. H.B. 64)

Draft Rule (ORC 4731.74):
- A physician may prescribe, dispense, or provide a prescription drug **that is not a controlled substance** to a person on whom the physician has never previously conducted a medical evaluation, and who is at a location remote from the physician, when the physician complies with the following:
  - Physician shall complete and document a medical evaluation and collection of relevant clinical history that conform to standards of care consistent with in-person care
  - Physician shall complete an examination of the patient using appropriate technology capable of transmitting images of the patient's condition in real-time
    - Exception if patient has designated primary care physician
  - Proper Documentation (including informed consent)
  - Physician shall maintain a medical record readily available to patient (including electronic prescription info)
  - Physician shall follow-up with patient to access therapeutic outcome

Draft Rule (OAC 4731-11-09):
- A physician may prescribe, dispense, or provide a **controlled substance** to a person on whom the physician has never conducted a medical evaluation in the following situations:
  - The person is a patient of a colleague of the physician and the drugs are provided pursuant to an on call or cross coverage arrangement between the physicians
  - The physician is consulting with another physician or health care provider who is authorized to practice in Ohio, and acting within the scope of their professional license and:
    - The physician shall establish the other physician/health care provider has an ongoing professional relationship with the patient and agrees to supervise the patient’s use of the drug
    - If a physician assistant, the physician has a supervision agreement
    - If a advanced registered practice nurse, the physician has a written standard care arrangement
  - The physician is a medical director or hospice physician and the patient to whom the drug is prescribed is enrolled in that hospice program
  - The person has been admitted as an inpatient to or is a resident of an institutional facility
Governor’s June 30, 2015 Veto Message Eliminating proposed ORC 4731.74

ITEM NUMBER 32

On page 8, delete the following boxed text “4731.74”.
On page 15, delete the following boxed text “4731.74”.
On page 1695, delete the boxed text.
On page 1696, delete the boxed text.
On page 1697, delete the boxed text.
On page 1698, delete the boxed text.

Prescribing Based on Remote Examination

This item sets practice of telemedicine requirements that may cause confusion about the appropriate standard of care for those who wish to offer telehealth services, particularly in light of the ongoing rulemaking process concerning the standards of telemedicine. The rulemaking process currently underway before the State Medical Board will allow all interested parties to present their views on how proposed standards for telemedicine can best protect the health and safety of the public. This provision may cause confusion about the proper standard of care for telemedicine and is unnecessary in light of the ongoing rulemaking process to set appropriate standards of care for telemedicine services. Therefore, this veto is in the public interest.
Nurse Practitioner and Physician Assistant:

- Independent prescribing authority upon obtaining certificate to prescribe.
- A nurse or physician assistant who holds a current valid certificate to prescribe shall prescribe in a valid prescriber-patient relationship. This may include, but is not limited to:
  - Obtaining a thorough history of the patient;
  - Conducting a physical or mental examination of the patient;
  - Rendering a diagnosis;
  - Prescribing medication, ruling out the existence of any recognized contraindication;
  - Consulting with the collaborating physician when necessary; and
  - Properly documenting the steps in the patient's medical record.

OAC 4723-9-09; OAC 4730-2-07

However, State Medical Board of Ohio interpretive guideline of OAC Rule 4731-11-09: “This document . . . provides guidance to physicians and others authorized prescribers (Advanced Practice Nurse or Physician Assistant)”
Consent

- 29 states include some sort of informed consent requirement in their statutes, administrative code, and/or Medicaid policies
  - Include: CA, FL, GA, KY, OH, TN, PA, TX, WV

**Kentucky – KY Admin Regs. 907, 3:170 (2011)**
(Medicaid):
Before providing telehealth consultation, providers must document written patient informed consent including:
1. Patient may refuse the telehealth consultation without affecting the right to future care or treatment
2. Recipient shall be informed of alternatives to telehealth consult
3. Dissemination, storage, or retention of identifiable recipient image or other information shall comply with state and federal confidentiality laws
4. Patient shall have right to be informed of the parties present at the spoke site and the hub site during consult and shall have the right to exclude anyone from either site;
5. Patient shall have right to object to videotaping of the consult

**Ohio – OAC 4753-2-01**
(Speech Language Pathology):
A provider is required to inform the patient of specific telehealth limitations

**California – CA Health & Safety Code Sec. 1374.13**
The originating site provider must obtain and document verbal or written patient consent prior to service delivery.
Privacy and Security

- HIPAA applies to telemedicine encounters and all necessary safeguards must be in place
- Challenges:
  - Secure wireless connection
  - Should web conferencing services (e.g. Skype, Face Time) have HIPAA-related obligations
    
    Skype is not a business associate subject to HIPAA, nor have we entered into any contractual arrangements with covered entities to create HIPAA-compliant privacy and security obligations. Instead, Skype is merely a conduit for transporting information, much like the electronic equivalent of the US Postal Service or a private courier. Skype does not use or access the protected health information (PHI) transmitted using our software. However, Skype has implemented a variety of physical, technical and administrative safeguards (including encryption techniques) aimed at protecting the confidentiality and security of the PHI that may be transmitted using Skype’s calling and video calling products. ~ Harvey Grasty

- Storage of electronic files, such as images or audio/video
- States with more aggressive laws
On February 9, 2015, the FDA issues Guidance on mobile medical apps:

- “The FDA is issuing this guidance document to inform manufacturers, distributors, and other entities about how the FDA intends to apply its regulatory authorities to select software applications intended for use on mobile platforms”
- “The FDA intends to apply its regulatory oversight to only those mobile apps that are medical devices and whose functionality could pose a risk to a patient’s safety if the mobile app were to not function as intended.”
When do FDA regulations apply?
- “When the intended use of a mobile app is for the diagnosis of disease or other conditions, or the cure, mitigation, treatment, or prevention of disease, or is intended to affect the structure or any function of the body of man, the mobile app is a device.”

Definition of “Mobile Medical App”:
- Mobile app that meet statutory definition of “device” and are intended and either are intended:
  1. To be used as an accessory to a regulated medical device; or
  2. To transform a medical platform into a regulated medical device

Mobile Apps FDA does not intend to enforce requirements:
- Mobile apps that help patients self-manage their diseases without providing specific treatment, provide easy access to information related to patients’ treatments; automate simple tasks for providers; help patients document, show, or communicate potential medical conditions to health care providers

Applicable regulatory requirements that apply: Quality system regulation, labeling, premarket notifications, registration, listing, and others.
OIG Advisory Opinion 11-12

Requestor provides neuroscience care through flagship hospital

Proposed Arrangement: Requester would provide services to certain community hospitals: (i) neuro emergency telemedicine technology; (ii) neuro emergency clinical consultations; (iii) acceptance of neuro emergency transfers; (iv) neuro emergency clinical protocols, training, and medical education

- Goal: to reduce volume of transfers of stroke patients, reduce mortality and morbidity rates, and lower costs
- OIG Conclusion: OIG would not impose administrative sanctions
Antikickback – OIG Advisory Opinion 11-12

- **OIG Rationale:**
  1. Requestor would be unlikely to generate appreciable referrals through the Arrangement – participating hospitals not encouraged to refer patients to Requestor’s hospital as a condition of Program participation
     - Express objective of Program is to **reduce** number of transfers
  2. Neither volume or value of a hospital’s previous or anticipated referrals, nor the volume or value of any other business generated between the parties, would be a condition of Program participation
  3. Primary beneficiaries of Arrangement is stroke patients, not the Participating Hospitals nor the Requestor
  4. Neither the Requestor nor any Participating Hospital would be required to engage in any marketing activities, and each party would be responsible for the costs associated with its own marketing activities.
  5. Arrangement unlikely to result in increased costs to Federal health care programs
State Telehealth Laws and Medicaid Program Policies

States without definitive reimbursement policies are:
1. Iowa
2. Massachusetts
3. Rhode Island

States without legal definition of telemedicine/telehealth:
1. New Jersey
2. Rhode Island
State Law Developments

Source: American Telemedicine Association 2015
Ohio Telemedicine Definition

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Ohio Telemedicine Law

- Informed Consent under Medicaid:
  - The originating site is responsible for obtaining informed consent. OAC 5160-1-18

- Medicaid Reimbursement Limitations:
  - When the originating site is located within a five mile radius from the distant site, providers are not eligible for reimbursement.
  - Provider types eligible as an originating site: primary care clinic, outpatient hospital, rural health clinic, FQHC, physician, professional medical group, podiatrist, optometrist. 

- Telemedicine Certificate
  - Out-of-state physicians who wish to practice telemedicine in Ohio must file an application with the state medical board. ORC 4731.296
On April 10, 2015, the Texas Medical Board voted to restrict the practice of telemedicine in Texas.

Texas board already required doctors to establish a “physician-patient relationship,” which includes establishing a diagnosis through an examination performed during a face-to-face encounter.

New rules state “Questions and answers exchanged through email, electronic text, or chat or telephonic evaluation of or consultation with a patient” are inadequate to establish a doctor-patient relationship.

New rule went into effect June 2015.
On June 30, 2015, the Colorado Medical Board issued a draft Telehealth Policy

- Licensure: A provider must be licensed to practice medicine in the state of Colorado in order to evaluate and treat patients located in Colorado.
- Provider-Patient Relationship: May be established using telehealth technologies so long as the relationship is established in conformance with generally accepted standards of practice.
- Evaluation: A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment must be obtained prior to providing treatment.
The Future – Telemedicine Kiosks

- HealthSpot Kiosks
  - Rollout 25 kiosks in Rite aids throughout Northeast Ohio
  - Pairs healthcare providers with videoconferencing and interactive medical devices
  - Cloud-based telemedicine software
  - Many that have used it so far are on Medicaid – instead of a $600 emergency room visit, Medicaid insurance companies pay $60
China

August 29, 2014, the National Health and Family Planning Commission of the People’s Republic of China (NHFPC) published interpretive guidance reflecting China’s efforts to promote the adoption and use of telemedicine, especially for US providers engaged in international telemedicine arrangements with China.

On January 15, 2015, the NHFPC issued a new document, outlining a plan to build a uniform national telemedicine service network in China. The “Technical Guidance” document is a 200-page blueprint on the creation of the network to enable large medical institutions to expand their services to regional and rural areas. Highlights include: supervision center to supervise telemedicine operations, healthcare insurance reimbursement program, recommended configurations, and protection of patient privacy and data security. Although aimed within China, US companies should consider the compatibility of their products.