Telemedicine Services and the Health Record (2013 update)

Save to myBoK

Editor's Note: This practice brief supersedes the April 1997 practice brief "Telemedical Records."

Telemedicine is a rapidly growing industry in the medical practice. Telemedicine is defined as telecommunications systems that link healthcare organizations and patients from diverse geographic locations and transmit text, data, and images for (clinical) consultation and treatment. This is seen as a cost-effective alternative to treating patients face-to-face, especially for patients living in rural communities. Telemedicine presents challenges to healthcare providers in ensuring that integrity and confidentiality are maintained, as well as ensuring the physician's scope of practice is within the legal statutes set forth by the state where the physician is practicing medicine. Providers must determine the individual responsible for documenting the information and how that information is shared.

This practice brief outlines the challenges of telemedicine, the planning for these services, and the best practices to ensure the clinical integrity of telemedical records. It is designed to support and guide organizations, health information management (HIM) professionals, and providers to understand, support, and execute best practices managing the telemedicine process.

Background

Telemedicine is a two-way, real time interactive communication between the patient and the physician at a remote site.

The delivery mechanisms include networked programs to link hospitals and clinics; point-to-point connections to deliver services directly or outsourced to independent providers; monitoring center links for in-home monitoring and other patient care services; and web-based e-health patient service sites for consumers.

"Closely associated with telemedicine is the term 'telehealth,' which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine and telehealth."[1]

Telemedicine is closely aligned with health information technology (health IT). Health IT more commonly refers to the electronic health record and related systems, while telemedicine refers to the actual delivery of remote health services using technology. However, the telemedicine records should become a part of the EHR to show the events of the visit.

The benefits of telemedicine are profound and at a minimum may include:

- Improved access to healthcare (i.e., obtaining second opinions, stroke care, cardiac monitoring, and urgent care services)
- Improved continuity of care, patient education, and timely treatment (i.e., monitoring the condition of chronically ill patients; reduced travel time for physicians, other healthcare providers, and patients; and better access for patients in underserved areas)
- Cost efficiencies (i.e., reducing or containing the cost of healthcare-increased efficiencies have also shown better chronic disease management and fewer or shorter hospital stays)
- Improved access to health records and information (i.e., promoting self-help by increasing the online availability of health information; knowledge-based self-diagnosis programs; distance learning programs, on-line discussion groups for peer support; and research data/information)
- Improved continuing medical education opportunities for special seminars with targeted groups in remote/rural locations; veterans of recent wars benefit from clinical trial research and patients can have improved interactions with physicians and other providers for disease education and management

Issues

Telemedicine technology in healthcare raises concerns. A number of issues must be addressed by organizations developing and using telemedicine programs:

Privacy, Confidentiality, and Security
Instant access to health information is beneficial to the medical community. However, this access may jeopardize patient privacy and the confidentiality of sensitive information. For example, there continues to be ethical concerns for social media when using unsecure technologies. The telemedicine event must be set up to ensure the privacy and security of the information that is transmitted. There are several delivery mechanisms that may be used to accomplish a secure connection:

- Networked programs link hospitals and clinics with outlying healthcare organizations in rural or suburban areas.
- Point-to-point connections using private networks connect hospitals and clinics that deliver services directly or contract out specialty services. Radiology and mental healthcare services are examples of contract specialties.
- Primary or specialty care to the home connects primary care providers, specialists, and home health nurses with patients over single line phone-video systems for interactive services.
- Home to monitoring center can be used for monitoring cardiac pulmonary patients at home. These services provide care to patients in the home. Normal phone lines often are used, although some systems may use the Internet.
- Web-based e-health patient service sites provide direct patient care and services over the Internet.

Liability
Traditionally, liability has been shared between the referring organization and physician and the consulting organization and/or physician. Telemedicine introduces new parties, such as the telemedicine vendor and technical staff. Consequently, because telemedicine is still not used predominantly, there is very little legal precedence.

Licensure and Accreditation
Because physician licensure is issued by states, a physician may not practice across state lines without being licensed in that state. Rules for accreditation and licensing may differ from state to state. A balance between access, safety, and quality will continue to be the ongoing focus as licensing and accreditation agencies address:

1. Medical practitioners (physician and non-physician) complying with all laws in each state they practice (whether electronically or physically)
2. Development of a system to provide effective monitoring of telemedicine practices across state lines
3. Establishment of clear standards for telemedicine practice and discipline

The Joint Commission has accreditation standards for originating and distant sites, distant-site telemedicine providers, and provision of telemedicine services at a hospital. These standards align with the requirements of the Centers for Medicaid and Medicare Services (CMS).

The Joint Commission Definitions

Originating site: The site where the patient is located at the time the service is provided.
Distant-site: The site where the practitioner providing the professional service is located.
Distant-site provider: A provider that has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.

Legislation
Currently there is no federal legislation addressing telemedicine. Most states have passed laws which specifically address telemedicine licensure and there are several states with telemedicine licensure bills pending. However, state legislation regarding licensure is not uniform. Some states require that a physician be fully licensed in the state where the patient is treated; others are more moderate and allow for episodic or occasional telemedicine or other consultations. States continue to explore ways in which they can expand the use of telemedicine.

Fraud
Resources to provide telemedicine services may be purchased from vendors. As a result, telemedicine service may be

dependent upon the vendor to ensure that information and data received or transmitted is current and accurate. This dependence could result in the potential for fraud and misrepresentation. Organizations should review their state anti-kickback laws and provisions to determine applicability to the activity, person rendering service, and the manner of performance to ensure compliance.

Reimbursement
Medicare does cover some telemedicine services for originating sites and distant site practitioners. Telemedicine services and professional services furnished via the telehealth site and the originating site organization fee may also be covered. Additional telehealth coverage is in proposed rulemaking for the 2013 Medicare Part B physician fee schedule.

Medicaid offers some reimbursement for telehealth services at the state level. Private payer reimbursement may be negotiated in contract specifics. The limited reimbursement continues to be a major barrier to telehealth expansion.

Planning for Services

Privacy, Confidentiality and Security
Telemedicine involves the electronic transmission of patient information, and tampering, unauthorized access, and interception are all issues to consider as a result. To safeguard information, covered entities must follow the Health Information Portability and Accountability Act (HIPAA) Privacy and Security Rule to include the updated rules under the Health Information Technology for Economic and Clinical Health Act (HITECH).

Telecommunication and Network Security
Telecommunication and network security needs to address the various structures for a network, methods of communication, formats for transporting data, and measures taken to secure the network and transmission.

- **Confidentiality**
    - Network security protocols
    - Network authentication services
    - Data encryption services
- **Integrity**
    - Firewall services
    - Communications security management
    - Intrusion detection services
- **Availability**
    - Fault tolerance for data availability (back-ups, redundant disk systems)
    - Acceptable log-ins and operating process performance
    - Reliable and interoperable security processes and network security mechanisms[2]

Developing policies and procedures promotes compliance with patient privacy and data security requirements. In addition to the above security considerations policies should be updated to address who can disclose the information upon receipt of a written authorization from the patient or legal representative:

- Either organization
- Referring organization only
- Consulting organization only
- In accordance with court order, subpoena, statute, or other

Physician Privileges and Licensure
Organizations should establish procedures to ensure that appropriate privileges and licensure are obtained.

In July 2011, CMS established a rule to facilitate implementation of telemedicine services at hospitals and critical access hospitals (CAH). The rule removed barriers for physicians in the credentialing process and aimed to increase the quantity and quality of care received. Hospitals may decide to rely on privileges and credentials of the home hospital that granted privileges to a physician seeking to provide telemedicine services. This proxy privileging (also known as delegated

credentialing) process should be reviewed by hospitals for necessary updates to medical staff bylaws, form agreements development, and evaluation of state peer review confidentiality standards. Furthermore, in May 2012, CMS added language to include "practitioner" (a non-physician) who has been granted privileges within their State's scope-of-practice law.

Although a national licensure model has not emerged, a standard mutual recognition system in which states adopt comparable legislation could allow practitioners to practice in any state. Such a voluntary method would streamline licensure procedures. Development of alternative models for cross state licensure continues by specific states, the Federation of State Medical Boards, the National Council of State Boards of Nursing, the Joint Working Group on Telemedicine (JWGT) and the American Telemedicine Association.

A national licensure has successfully been adopted by the Veterans Administration (VA), Indian Health Service, and Public Health Service. Current legislation in the House of Representatives as of July 2012 supports removing restrictions that currently prevent VA providers from practicing across state lines when they are not licensed in the same state as their patient.

Fraud
Ensure that vendor contracts are sensitive to misrepresentation of services and fraud. Establish appropriate quality controls.

Policy and Procedures
Develop appropriate policies and procedures for telemedical services before starting a program to ensure consistency in the documentation by both the physician and patient. A sample outline follows:

For Hospital or Physician

- Introduction
- References
- Scope
- Procedures
- Orientation/Training of Staff
- Using the Equipment
- Orienting the Member to Telemedicine
- Confidentiality/Privacy
- Video Recording of Telemedicine Services
- Clinical Record Keeping
- Medication Prescriptions
- Appropriate Telemedicine Services
- Reporting Telemedicine Statistics
- Technical Quality of Telemedicine
- Prioritization of Clinical Telemedicine
- Monitoring

For Provider

- Application
- Overview
- Reimbursement
- Telehealth services
- Modifiers
- Telephone Calls
- Internet Services
- Definitions
- Q & A
- Codes & Explanation
- Attachments
- References

Processes
Define the goals for the service. Based on the goals, define the needs or requirements involving all interested parties, including appropriate clinical staff, legal counsel or risk manager, HIM professionals, and information systems professionals.

Design around the patient care needs, not around the technology. Design the process for minimal variation from other patient encounters. For example, the creation of "telemedical" forms is not required. Use forms already in place and modify them only if necessary. Incorporate telemedical records in your current processes rather than establishing parallel processes for them. Establish procedures to ensure that all parties have appropriate health and billing information, consents, and authorizations prior to the telemedical encounter. When the referring and consulting physician/organization partner together regularly, preparing a written agreement of the documentation that will be required is a helpful extra step to consider.

Documentation Requirements

As telemedicine services are rendered, capturing the documentation and ensuring the accuracy and timely completion has been a challenge for many organizations. However, based on those who have telemedicine programs in place, it can be concluded that telemedical records requirements, regardless of media, are the same as for other health records. Therefore, the information of the visit, the history, review of systems, consultative notes, or any information used to make a decision about the patient must be addressed.

Telemedical record content is not specifically addressed in the standards of the Joint Commission, the National Committee for Quality Assurance, the American Osteopathic Association, the US Department of Health and Human Services, or the Accreditation Association for Ambulatory Health Care.

Telemedical records should be consistent, accurate, and timely, and should contain non-duplicative documentation. Policy should address maintenance of images or recordings that should be considered part of the patient's health record and should be retained according to state retention laws. Availability and location should be noted in the health record. Redundant systems for electronic records should be maintained and an emergency plan established in case of electronic system failure.

Telemedical records should be kept in the same manner as health records. The specific documentation needed varies depending upon the level of telemedical interaction. The organization using the telemedical information to make a decision on the patient's treatment must comply with all standards, including the need for assessment, informed consent, documentation of event (regardless of the media), and authentication of record entries.

Standards/Requirements: Content
At minimum, AHIMA recommends that each telemedical record contain the following:

- Patient name
- Identification number
- Date of service
- Referring physician
- Consulting physician
- Provider organization
- Type of evaluation performed
- Informed consent, if appropriate (In many telemedicine programs, the referring physician/organization retains the original and a copy is sent to the consulting physician/organization)
- Evaluation results (In many telemedicine programs, the consulting physician/organization retains the original and a copy is sent to the referring physician/organization)
- Diagnosis/impression
- Recommendations for further treatment

It is also important to ensure that patient registration information needed by the consulting physician/organization is obtained, in addition to information routinely obtained. Retention of telemedical records should be in accordance with state laws or regulations and any reimbursement requirements. Maintenance of telemedical records should ensure that the organization can quickly assemble all components of a patient's record, regardless of their location in the organization. In the absence of policies specifically addressing disclosure of telemedical information, disclosure should be allowed upon receipt of written authorization from the patient or legal representative or in accordance with court order, subpoena, or statute. Informed consent for telemedical encounters should include the names of both the referring physician and the consulting physician, and it should inform the patient that his/her health information will be electronically transmitted. Telemedical records media may be hard copy, video or audiotape, monitor strip, or electronic files. Some states specify acceptable media for health records. Review the appropriate state laws and regulations for any specific requirements. To avoid duplication of information and determine custodianship, identify the responsible holder and owner of the legal telemedicine record.

Notes

1. American Telemedicine Association. "What is Telemedicine?"
2. Kurtz, Ronald L., and Russell Dean Vines. *The CISSP Prep Guide (Gold Edition)*. Indianapolis, IN: Wiley, 2003, p. 345.

References

American Telemedicine Association. "Telehealth Proposed Expansion for Medicare." July 2012.

Brandt, Mary. *Maintenance, Disclosure, and Redisclosure of Health Information*. Chicago, IL: AHIMA Press, 1995.

Bowman, Dan. "Telemedicine Bill Enables VA Providers to Practice Across State Lines." *FierceHealth IT*. July 16, 2012.

Centers for Medicare and Medicaid Services. "Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation." *Federal Register*. Vol. 77, No. 95. 42 CFR Parts 482 and 485. May 16, 2012.

Department of Health and Human Services. "Telehealth Services: Rural Health Fact Sheet Series." December 2012.

Health Capital Consultants. *Health Capital Topics*. Vol. 4, No. 5. May 2011.

Huston, Janis L. "A Telemedical Record Model." *Journal of Telemedicine and Telecare* Vol. 3, Supplement 1 (1997): 86-88.

Huston, Janis L. "Telemedical Records: The Weak Link in Telemedicine." *Journal of AHIMA* 67, no. 6 (1996): 69-71.

Knutson, Julie. "Moving Care Across State Lines." *For The Record* Vol. 13 No. 5 (March 2012). www.fortherecordmag.com.

Lorton, L., and J. D. Legler. "A Telemedicine Trial." *Journal of AHIMA* 67, no. 4 (1996): 40-42.

Natoli, Christa. "Summary of Findings: Malpractice and Telemedicine." Center for Telehealth & e-Health Law (2009).

New York State Department of Health. "Statements on Telemedicine." January 2009.

O'Reilly, Kevin. "Telemedicine can pose Ethical Problems, Delegates Warn." July 2, 2102. *American Medical News*.

Perednia, Douglas A. "Telemedicine System Evaluation, Transaction Models, and Multicentered Research." *Journal of AHIMA* 67, no. 1 (1996): 60-63.

Telehealth Resource Centers. "Telehealth Legal and Regulatory Module."

The Joint Commission. *Comprehensive Accreditation Manual for Ambulatory Care*. Updated October 12, 2012.

The Joint Commission. *Comprehensive Accreditation Manual for Hospitals*. Updated October 12, 2012.

Youngstrom, Nina. "With Use of Telehealth Expected to Grow, Hospitals Confront Fraud, HIPAA Pitfalls." *AIS Health*. March 19, 2012.

Prepared by

Marlene L. Johnson, RHIA
Diana Warner, MS, RHIA, CHPS, FAHIMA

Acknowledgements

Cecilia Backman, MBA, RHIA, CPHQ
Jean Clark, RHIA, CSHA
Jill Clark, MBA, RHIA, CHDA
Linda Darvill, RHIT
Jane DeSpiegelaere, MBA, RHIA, CCS, FAHIMA

Stacy Jowers Dorris, MBA, RHIA, CPHQ
Kim Turtle Dudgeon, RHIT, HIT Pro-IS/TS, CMT
Stevan Hidalgo, RHIA, CHPS
Sandra Huyck, RHIT, CCS-P, CPC, CPC-H
Theresa Jones, MSED, RHIA
Carole Liebner, RHIT, CCS
Stephanie Luthi-Terry, MA, RHIA, FAHIMA
Kimberly Baldwin-Stried Reich, MBA, MJ, PBCI
Angela Dinh Rose, MHA, RHIA, CHPS
M. Beth Shanholtzer, MAEd, RHIA
Sharon Slivochka, RHIA
Traci Waugh, RHIA
Lou Ann Wiedemann, MS, RHIA, FAHIMA, CDIP, CPEHR

Original

Donna M. Fletcher, MPA, RRA

Original Acknowledgments

Mary Brandt, MBA, RRA, CHE
James Braden, MBA
Alexa Cross, MA, RRA
Jill Callahan Dennis, JD, RRA
Sandy Fuller, MA, RRA
Patricia C. Hanson, RN
Louis Head, MD
Janis L. Huston, MEd, RRA
Kathleen Kuha
Harry Rhodes, MBA, RRA
Janet Silversmith
Colin J. Zick, JD

Article citation:
AHIMA Practice Brief. "Telemedicine Services and the Health Record (2013 update)" (Updated May 2013)
