



REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-14)
Coverage of and Payment for Telemedicine
(Reference Committee A)

EXECUTIVE SUMMARY

Telemedicine, a key innovation in support of health care delivery reform, is being used in initiatives to improve access to care, care coordination and quality, as well as reduce the rate of growth in health care spending. The evolution of telemedicine impacts all three strategic focus areas of the American Medical Association (AMA): improving health outcomes, accelerating change in medical education, and enhancing physician satisfaction and practice sustainability by shaping delivery and payment models.

The definition of telemedicine, as well as telehealth, has continued to evolve, and there is no consensus on the definition of either of the two terms. Today, there are three broad categories of telemedicine technologies: store-and-forward, remote monitoring, and (real-time) interactive services. The coverage of and payment for telemedicine services vary widely. While public and private payers have continued to develop formal mechanisms to pay for telemedicine services, inconsistencies remain that create barriers to the further adoption of telemedicine.

The standards of care and practice guidelines relevant to telemedicine are evolving and vary based on specialty and service provided. A number of national medical specialty societies have developed clinical guidelines and position statements addressing telemedicine while others have initiated steps to do so. Besides the specialty societies, the American Telemedicine Association (ATA)—an organization comprised of a cross-section of stakeholders including, for example, insurers, telecommunication providers, vendors, and individual physicians and other providers—has spear-headed a guideline development process for telemedicine with varying levels of engagement of medical specialty societies.

With a growing number of services being provided via telemedicine technologies, there is a need for a set of safeguards and standards in AMA policy to support the appropriate coverage of and payment for telemedicine services. In this report, the Council recommends a set of principles to ensure the appropriate coverage of and payment for telemedicine services. These principles aim to support future innovation in the use of telemedicine, while ensuring patient safety, quality of care and the privacy of patient information, as well as protecting the patient-physician relationship and promoting improved care coordination and communication with medical homes. Before physicians provide any telemedicine service, they should verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable.

Because the coverage of and payment for telemedicine services is related to the evidence in support of telemedicine, the report also includes recommendations supporting additional research, pilot programs and demonstration projects regarding telemedicine. In order to ensure quality of care, patient safety, and coordination of care in the provision of telemedicine services, the report's recommendations reiterate the importance of national medical specialty societies continuing to be involved in the development of appropriate and comprehensive practice parameters, standards and guidelines to address the clinical and technological aspects of telemedicine.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-14

Subject: Coverage of and Payment for Telemedicine

Presented by: Charles F. Willson, MD, Chair

Referred to: Reference Committee A
(Gary L. Bryant, MD, Chair)

1 Telemedicine, a key innovation in support of health care delivery reform, is being used in
2 initiatives to improve access to care, care coordination and quality, as well as reduce the rate of
3 growth in health care spending. The evolution of telemedicine impacts all three strategic focus
4 areas of the American Medical Association (AMA): improving health outcomes, accelerating
5 change in medical education, and enhancing physician satisfaction and practice sustainability by
6 shaping delivery and payment models. This Council-initiated report provides background on the
7 delivery of telemedicine; outlines coverage and payment rules of public and private payers
8 addressing telemedicine; summarizes specialty society practice guidelines and position statements
9 on telemedicine; highlights case studies on telemedicine; summarizes relevant AMA policy and
10 presents policy recommendations.

11

12 BACKGROUND

13

14 In 1996, the Institute of Medicine (IOM) released its report “Telemedicine: A Guide to Assessing
15 Telecommunications for Health Care,” which defined telemedicine as “the use of electronic
16 information and communications technologies to provide and support health care when distance
17 separates participants.” The IOM report on telemedicine also stated that:

18

19 ... telemedicine is not a single technology or a discrete set of related technologies; it is, rather,
20 a large and very heterogeneous collection of clinical practices, technologies, and organizational
21 arrangements. In addition, widespread adoption of effective telemedicine applications depends
22 on a complex, broadly distributed technical and human infrastructure that is only partly in
23 place and is being profoundly affected by rapid changes in health care, information, and
24 communications systems.¹

25

26 Since the release of the IOM report, the definition of telemedicine, as well as telehealth, has
27 continued to evolve, and there is no consensus on the definition of either of the two terms. Today,
28 there are three broad categories of telemedicine technologies: store-and-forward, remote
29 monitoring, and (real-time) interactive services.

30

31 Store-and-forward telemedicine involves the transmittal of medical data (such as medical images
32 and bio signals) to a physician or medical specialist for assessment. It does not require the presence
33 of both parties at the same time and has thus become popular with specialties such as dermatology,
34 radiology and pathology, which can be conducive to asynchronous telemedicine.

1 Remote monitoring, or self-monitoring or testing, enables medical professionals to monitor a
2 patient remotely using various technological devices. This method is typically used to manage
3 chronic diseases or specific conditions (e.g., heart disease, diabetes mellitus, or asthma), as devices
4 that can be used by patients at home to capture such health indicators as blood pressure, glucose
5 levels, ECG and weight.

6
7 Interactive telemedicine services provide real-time, face-to-face interaction between patient and
8 provider (e.g., online “portal” communications). Telemedicine, where the patient and provider are
9 connected through real-time audio and video technology (generally a requirement for payment) has
10 been used as an alternative to the traditional method of care delivery, and in certain circumstances
11 can be used to deliver such care as the diagnosis, consultation, treatment, education, care
12 management and self-management of patients.

13 14 COVERAGE OF AND PAYMENT FOR TELEMEDICINE

15
16 The coverage of and payment for telemedicine services vary widely. The passage of the Balanced
17 Budget Act of 1997 and the Telemedicine Communications Act of 1996 enabled payment for
18 professional telemedicine consultation in 1999. While public and private payers have continued to
19 develop formal mechanisms to pay for telemedicine services, inconsistencies remain that create
20 barriers to the further adoption of telemedicine.

21 22 *Medicare*

23
24 Each year, Medicare pays approximately \$6 million for telemedicine services. In 2009, there were
25 approximately 40,000 telemedicine visits, involving some 14,000 Medicare beneficiaries. That
26 same year, 369 practitioners, including physicians, provided 10 or more telemedicine services to
27 Medicare beneficiaries, most of which were mental health services. Psychiatrists, psychologists and
28 clinical social workers comprised 49 percent of the practitioners who provided 10 or more
29 telemedicine services in Medicare. While physician assistants, nurse practitioners and clinical nurse
30 specialists accounted for 19 percent of such practitioners, family medicine and internal medicine
31 physicians accounted for seven percent.²

32
33 Medicare provides payment to physicians and other health professionals for a relatively narrow list
34 of Part B services that are provided via telemedicine. Eligible services include: initial and follow-
35 up inpatient consultations; office or other outpatient visits; psychiatric diagnostic interview
36 examinations; end-stage renal disease related services; neurobehavioral status exams; screenings
37 for sexually transmitted infections (STIs) and high intensity behavioral counseling to prevent STIs;
38 and intensive behavioral therapy for cardiovascular disease. In its final 2014 Physician Fee
39 Schedule (PFS) rule, the Centers for Medicare & Medicaid Services (CMS) expanded telemedicine
40 service codes that will be paid by Medicare to include transitional care management services (CPT
41 codes 99495 and 99496). There is also an opportunity to request that services be added to the list
42 of telemedicine services covered by Medicare, outlined at www.cms.gov/telehealth.

43
44 The originating sites where Medicare beneficiaries receiving services via telemedicine are located
45 are limited to qualified centers in areas defined as rural Health Professional Shortage Areas
46 (HPSAs), counties outside metropolitan statistical areas, and areas approved by the government for
47 demonstration of telemedicine. Of note, in its Medicare 2014 PFS final rule, CMS expanded
48 geographic locations where telemedicine services may be covered by Medicare by changing its
49 definition of rural HPSAs to those located in rural census tracts as determined by the Office of
50 Rural Health Policy.

1 The telemedicine services covered by Medicare are required to have both interactive audio and
2 video with real-time communication. Coverage of store-and-forward telemedicine services is
3 currently only allowed in Hawaii and Alaska as part of a demonstration program. Additional
4 requirements for in-person visits exist for certain illnesses. Payment modifiers are used to code
5 telemedicine services, and physicians are paid under the PFS. Physicians and other practitioners
6 who provide a service via telemedicine must be paid an amount equal to the amount that the
7 practitioner would have been paid if the service had been provided without the use of telemedicine.
8 If a prescriber has reassigned billing rights to a Critical Access Hospital, payment is 80 percent of
9 the Medicare PFS for telemedicine services.

10
11 Medicare Advantage plans are exempt from these limitations placed on telemedicine services
12 provided to Medicare fee-for-service beneficiaries. The Council notes that there is increasing
13 momentum in Congress to also exempt physicians and other health practitioners who participate in
14 alternative payment models from the aforementioned telemedicine limitations that otherwise exist
15 in Medicare.

16 17 *Other Payers*

18
19 Forty-six states and the District of Columbia (DC) offer some form of Medicaid payment for
20 telemedicine services. While the Medicaid programs in all of these states and DC pay for some
21 services administered via real-time audio and video technologies, the Medicaid programs in only
22 nine states at some level pay for store-and-forward, and 14 states pay for remote patient
23 monitoring.³ In addition, 19 states and DC have adopted laws mandating that private payers cover
24 what the states deem as telemedicine services (definitions vary by state).⁴ State coverage of and
25 payment for telemedicine services are related to state laws addressing what services providers can
26 and cannot deliver remotely and what requirements need to be met in order to do so. The Council
27 notes that there is little consistency among states in how telemedicine is defined and regulated.

28
29 Some of the leading private health insurers provide coverage and payment for telemedicine, with
30 varying approaches to doing so. Some private insurers, including WellPoint, Aetna and Highmark
31 have partnered with telemedicine companies that offer health consultations with very different
32 technology models and standard operating procedures for interactions between patients and the
33 health care providers. Examples of the significant variability in technology platforms and
34 measures to facilitate care coordination include on one end of the spectrum, collaborations which
35 offer two-way interactive video platforms and the ability to interact with a physician, and on the
36 other end, partnerships with companies that primarily offer telephone communications between a
37 patient and a health care provider.

38 39 SPECIALTY SOCIETY PRACTICE GUIDELINES AND POSITION STATEMENTS

40
41 The standards of care and practice guidelines relevant to telemedicine are evolving and vary based
42 on specialty and service provided. The AMA has surveyed both national medical specialty
43 societies and state medical associations concerning practice guidelines as well as policies broadly
44 governing telemedicine. A number of specialty societies have developed clinical guidelines and
45 position statements addressing telemedicine while others have initiated steps to do so. Examples of
46 clinical guideline development include the American Academy of Child and Adolescent
47 Psychiatry's practice parameter for telepsychiatry with children and adolescents, the Society of
48 American Gastrointestinal and Endoscopic Surgeons' guidelines for the surgical practice of
49 telemedicine, and the American College of Radiology/Society for Imaging Informatics in
50 Medicine's practice guidelines for electronic medical information privacy and security.

1 Besides medical specialty societies, the American Telemedicine Association (ATA)—an
2 organization comprised of a cross-section of stakeholders including, for example, insurers,
3 telecommunication providers, vendors, and individual physicians and other providers—has spear-
4 headed a guideline development process for telemedicine with varying levels of engagement of
5 medical specialty societies. For example, the American Academy of Dermatology (AAD)
6 provided input on the use of the Practice Guidelines for Teledermatology, developed by the ATA.
7 The ATA also released practice guidelines for video-based online mental health services, which
8 were developed with input from the American Psychiatric Association (APA). It is anticipated that
9 national medical specialty societies will take a greater role in the development and approval of
10 telemedicine clinical practice guidelines.

11

12 Along with many other specialty societies, including the American College of Physicians, the
13 American Academy of Family Physicians, the American Osteopathic Association, and AAD, APA
14 also has a position statement on the ethical use of telemedicine. The American College of
15 Radiology also issued a white paper on teleradiology practice, and the Telemedicine Work Group
16 of the American Academy of Neurology issued a report on teleneurology applications.

17

18 CASE STUDIES OF TELEMEDICINE

19

20 As outlined in the highlighted case studies below, there is a range of medical services being
21 delivered via telemedicine by physicians and other health professionals. Telemedicine services are
22 provided by hospitals, specialty departments, home health agencies and private physician offices.
23 While some telemedicine programs are multispecialty in nature, others are tailored to specific
24 diseases and medical specialties.

25

26 *University of Virginia (UVA) Center for Telehealth*

27

28 The UVA Center for Telehealth works across the UVA Telemedicine Partner Networks, which
29 includes 118 sites to offer telemedicine services in more than 40 specialties and sub-specialties.
30 Services provided include single consultations and follow-up visits, emergency consultations, and
31 screenings using store-and-forward technologies, such as mobile digital mammography and
32 retinopathy. Depending on the specialty, the patient may need to have an initial in-person visit
33 with the specialist at UVA and then continue with follow-up appointments via telemedicine. The
34 Center has provided more than 33,000 patient encounters in Virginia, and provides more than
35 30,000 teleradiology services per year.⁵ The Center accepts referrals from other physicians, as well
36 as direct appointments from patients. After the appointment with a physician of the UVA Center
37 for Telehealth, to ensure continuity of care, the referring physician, if any, and/or the patient's
38 primary care physician, is provided a report with follow-up information.

39

40 *Arkansas ANGELS*

41

42 The Antenatal & Neonatal Guidelines, Education & Learning System (ANGELS) of the University
43 of Arkansas for Medical Services (UAMS) provides patients with around-the-clock and telemedical
44 support to address high-risk obstetrical care needs. With approximately thirty telemedicine sites,
45 ANGELS delivers subspecialty care services to high-risk mothers and their infants. Notably,
46 UAMS houses many of state's only board-certified maternal-fetal medicine specialists and genetic
47 counselors. ANGELS uses a variety of telemedicine technologies to deliver care, including
48 specialized ultrasound equipment that digitally transfers a sonogram image to UAMS, as well as
49 special devices to perform colposcopies via telemedicine to allow for remote cervical examination
50 and biopsy. In 2012, there were 5,221 telemedicine visits as part of ANGELS, as well as 2,062

1 telemedicine obstetric ultrasound visits and 130 fetal echocardiogram visits. Also in 2012, 1,629
2 colposcopy exams were provided, which identified 303 women with high-grade lesions requiring
3 treatment and five diagnosed with cancer.⁶

4
5 *AccessDerm*

6
7 AccessDerm is a teledermatology program sponsored by the AAD that provides primary care
8 practitioners working in participating clinics caring for underserved patients with free access to
9 dermatologic consultations of AAD members. The primary care practitioner and participating
10 AAD-member dermatologist use either personal mobile devices or the Internet to transmit the
11 information required for the consultation. AccessDerm consultations comply with HIPAA
12 requirements for the privacy and security of patient information. As of the drafting of this report,
13 16 states have clinics registered to participate in the program. As of February 18, 2014,
14 AccessDerm has provided more than 960 consultations to underserved patients, which have
15 included diagnoses of a previously undiagnosed melanoma and a Kaposi's sarcoma.⁷

16
17 **AMA POLICY**

18
19 *Payment*

20
21 AMA policy states that physicians should uniformly be compensated for their professional services
22 at a fair fee for established patients with whom the physician has had previous face-to-face
23 professional contact, whether the current consultation service is rendered by telephone, fax,
24 electronic mail or other forms of communication (Policy H-390.859). Policy H-390.859 also calls
25 for CMS and other payers to separately recognize and adequately pay for non-face-to-face
26 electronic visits. Likewise, Policy H-480.961 states that CMS should reimburse telemedicine
27 services in a fashion similar to traditional payments for all other forms of consultation, which
28 involves paying the various providers for their individual claims, and not by various "fee splitting"
29 or "fee sharing" payment schemes. Policy H-480.974 states that the AMA will work with CMS and
30 other payers to develop and test appropriate payment mechanisms for telemedicine through
31 demonstration projects aimed at evaluating the effect of care delivered by physicians using
32 telemedicine-related technology on costs, quality, and the patient-physician relationship. Policy
33 H-385.919 supports pilot projects of innovative payment models being structured to include
34 incentive payments for the use of electronic communications such as Web portals, remote patient
35 monitoring, real-time virtual office visits, and email and telephone communications.

36
37 *Clinical standards*

38
39 Policies H-480.974, H-480.968 and H-480.969 encourage national specialties to develop
40 appropriate and comprehensive practice parameters, standards and guidelines to address the clinical
41 and technological aspects of telemedicine. Policy H-480.968 urges national private accreditation
42 organizations to require that medical care organizations that establish ongoing arrangements for
43 medical care delivery from remote sites require practitioners at those sites to meet no less stringent
44 credentialing standards and participate in quality review procedures that are at least equivalent to
45 those at the site of care delivery.

1 *Licensure*

2
3 Policy H-480.969 states that medical boards of states and territories should require a full and
4 unrestricted license in that state for the practice of telemedicine, and outlines principles for any
5 telemedicine license category. Policy D-480.999 opposes a single national federalized system of
6 medical licensure. Policy H-160.937 outlines principles for the supervision of non-physician
7 providers and technicians when telemedicine is used.

8
9 *Ethical guidance*

10
11 Opinion E-5.025, issued in 1994, prohibits physicians from providing any clinical services via
12 telecommunications. As stated in Board of Trustees Report 22-A-13, this opinion may no longer be
13 consistent with best ethical analysis or strong practice in the rapidly evolving area of telemedicine.
14 As such, Policy D-480.974 states that the Council on Ethical and Judicial Affairs (CEJA) will
15 review Opinions relating to telemedicine and update the Code of Medical Ethics as appropriate. A
16 CEJA report examining ethical guidance in this area is in development.

17
18 **DISCUSSION**

19
20 As telemedicine continues to evolve, with a growing number of services being provided via
21 telemedicine technologies, the Council firmly believes that there is a need for a set of safeguards
22 and standards in AMA policy to support the appropriate coverage of and payment for telemedicine
23 services. Such standards and safeguards need to support future innovation in the use of
24 telemedicine, while ensuring patient safety, quality of care and the privacy of patient information,
25 as well as protecting the patient-physician relationship and promoting improved care coordination
26 and communication with medical homes.

27
28 Prior to delivering services via telemedicine, the Council believes a valid patient-physician
29 relationship must be established, through at minimum a face-to-face examination, if a face-to-face
30 encounter would otherwise be required in the provision of the same service not delivered via
31 telemedicine. The face-to-face encounter could occur in person or virtually through real-time audio
32 and video technology. Also, before a telemedicine service is provided, the physician or other
33 health professional must notify the patient of cost-sharing responsibilities and limitations in drugs
34 that can be prescribed via telemedicine. When a service is delivered using telemedicine,
35 mechanisms to ensure continuity of care, follow-up care and referrals for emergency services must
36 be in place.

37
38 The Council believes that key tenets in the delivery of in-person services hold true for the delivery
39 of telemedicine services. Notably, physicians and other health practitioners delivering telemedicine
40 services must abide by state licensure laws and requirements as well as state medical practice laws
41 including, for example, laws concerning consent involving minors, prescribing, reproductive rights,
42 end-of-life, and scope. In addition, prior to the delivery of any telemedicine service, physicians
43 need to verify that their medical liability insurance policy covers telemedicine services, including
44 telemedicine services provided across state lines if applicable. It is essential that patients have
45 access to the licensure and board certification qualifications of the health care practitioners who are
46 providing the care in advance of their visit.

47
48 The scope of the coverage of and payment for telemedicine services is directly correlated to the
49 strength of the evidence base in support of telemedicine. While there is an emerging body of
50 evidence suggesting that delivering services via telemedicine could contribute to improving patient

1 health outcomes, additional evidence needs to be compiled to ensure quality of care and patient
2 safety. In addition to investing in research focused on the delivery of care via telemedicine,
3 additional pilot programs and demonstration projects should be supported.

4
5 To ensure quality of care, patient safety, and coordination of care in the provision of telemedicine
6 services, the Council believes it is essential for national medical specialty societies to continue to
7 develop appropriate and comprehensive practice parameters, standards and guidelines to address
8 the clinical and technological aspects of telemedicine, as called for in Policies H-480.974,
9 H-480.968 and H-480.969. In addition, the Council notes that it is essential that specialty societies
10 leverage, to the extent practicable, the work of national telemedicine organizations, including the
11 ATA, in the area of technical standards and take the lead in the development of clinical practice
12 guidelines for telemedicine.

13 14 RECOMMENDATIONS

15
16 The Council on Medical Service recommends that the following be adopted and the remainder of
17 the report be filed:

- 18
19 1. That American Medical Association (AMA) policy be that telemedicine services should be
20 covered and paid for if they abide by the following principles:
- 21
22 a) A valid patient-physician relationship must be established before the provision of
23 telemedicine services, through:
 - 24 • A face-to-face examination, if a face-to-face encounter would otherwise be required in
25 the provision of the same service not delivered via telemedicine;
 - 26 • A consultation with another physician who has an ongoing patient-physician
27 relationship with the patient. The physician who has established a valid physician-
28 patient relationship must agree to supervise the patient's care; or
 - 29 • Meeting standards of establishing a patient-physician relationship included as part of
30 evidence-based clinical practice guidelines on telemedicine developed by major
31 medical specialty societies, such as those of radiology and pathology.
 - 32 Exceptions to the foregoing include on-call, cross coverage situations; emergency medical
33 treatment; and other exceptions that become recognized as meeting or improving the
34 standard of care. If a medical home does not exist, telemedicine providers should facilitate
35 the identification of medical homes and treating physicians where in-person services can
36 be delivered in coordination with the telemedicine services.
 - 37 b) Physicians and other health practitioners delivering telemedicine services must abide by
38 state licensure laws and state medical practice laws and requirements in the state in which
39 the patient receives services.
 - 40 c) Physicians and other health practitioners delivering telemedicine services must be licensed
41 in the state where the patient receives services, or be providing these services as otherwise
42 authorized by that state's medical board.
 - 43 d) Patients seeking care delivered via telemedicine must have a choice of provider, as
44 required for all medical services.
 - 45 e) The delivery of telemedicine services must be consistent with state scope of practice laws.
 - 46 f) Patients receiving telemedicine services must have access to the licensure and board
47 certification qualifications of the health care practitioners who are providing the care in
48 advance of their visit.

- 1 g) The standards and scope of telemedicine services should be consistent with related in-
2 person services.
- 3 h) The delivery of telemedicine services must follow evidence-based practice guidelines, to
4 the degree they are available, to ensure patient safety, quality of care and positive health
5 outcomes.
- 6 i) The telemedicine service must be delivered in a transparent manner, to include but not be
7 limited to, the identification of the patient and physician in advance of the delivery of the
8 service, as well as patient cost-sharing responsibilities and any limitations in drugs that can
9 be prescribed via telemedicine.
- 10 j) The patient's medical history must be collected as part of the provision of any telemedicine
11 service.
- 12 k) The provision of telemedicine services must be properly documented and should include
13 providing a visit summary to the patient.
- 14 l) The provision of telemedicine services must include care coordination with the patient's
15 medical home and/or existing treating physicians, which includes at a minimum identifying
16 the patient's existing medical home and treating physician(s) and providing to the latter a
17 copy of the medical record.
- 18 m) Physicians, health professionals and entities that deliver telemedicine services must
19 establish protocols for referrals for emergency services.
- 20
- 21 2. That AMA policy be that delivery of telemedicine services must abide by laws addressing the
22 privacy and security of patients' medical information. (New HOD Policy)
- 23
- 24 3. That our AMA encourage additional research to develop a stronger evidence base for
25 telemedicine. (New HOD Policy)
- 26
- 27 4. That our AMA support additional pilot programs in the Medicare program to enable coverage
28 of telemedicine services, including, but not limited to store-and-forward telemedicine. (New
29 HOD Policy)
- 30
- 31 5. That our AMA support demonstration projects under the auspices of the Center for Medicare
32 and Medicaid Innovation to address how telemedicine can be integrated into new payment and
33 delivery models. (New HOD Policy)
- 34
- 35 6. That our AMA encourage physicians to verify that their medical liability insurance policy
36 covers telemedicine services, including telemedicine services provided across state lines if
37 applicable, prior to the delivery of any telemedicine service. (New HOD Policy)
- 38
- 39 7. That our AMA encourage national medical specialty societies to leverage and potentially
40 collaborate in the work of national telemedicine organizations, such as the American
41 Telemedicine Association, in the area of telemedicine technical standards, to the extent
42 practicable, and to take the lead in the development of telemedicine clinical practice guidelines.
43 (New HOD Policy)
- 44
- 45 8. That our AMA reaffirm Policies H-480.974, H-480.968 and H-480.969, which encourage
46 national medical specialty societies to develop appropriate and comprehensive practice
47 parameters, standards and guidelines to address the clinical and technological aspects of
48 telemedicine. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500

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