Practice Challenges of Intensive Care Unit Telemedicine

Herb Rogove, DO[a,*], Kory Stetina, CPC[b]

KEYWORDS

• TeleICU • Telemedicine • Telehealth • Medical license portability • Reimbursement • Telemedicine credentialing • Billing • Coding

KEY POINTS

- Understanding the key challenges that face the practice of telemedicine and how that impedes the spread of technology for the benefit of telemedicine-provided patient care.
- Why state medical licensure has remained a key barrier for the adaption of telemedicine for many years.
- How hospital staff credentialing is a time-consuming activity that could easily be simplified by credentialing-by-proxy and other process improvements.
- Medicare, Medicaid, and private insurance guidelines for telehealth reimbursement can be easily accessed and analyzed, and in many cases demonstrate available reimbursement for Tele-ICU programs.
- Understanding telehealth reimbursement guidelines and the appropriate billing codes for the Tele-ICU program can empower providers to develop detailed financial projections for Tele-ICU services.

INTRODUCTION

The practice of intensive care unit (ICU) telemedicine or Tele-ICU has been available for approximately 20 years. A recently published lexicon described the types of Tele-ICUs that exist, ranging from a centralized model to a de-centralized model; open, closed, or hybrid architecture; fixed or portable technology; and care models that range from continuous, scheduled, or reactive.[1] Regardless of the model that is adapted by a hospital or health system, there are significant impediments in starting and maintaining a Tele-ICU practice. In a survey of acute-care practitioners using telemedicine, it was noted that procurement of state medical licenses, credentialing, and reimbursement

Disclosures: None.
[a] C3O Telemedicine, 1119 North Signal Street, Ojai, CA 93023, USA; [b] Torch Health Solutions, 4740 32nd Street, San Diego, CA 92116, USA
* Corresponding author.
E-mail address: herb.rogove@c3otelemedicine.com

Crit Care Clin 31 (2015) 319–334
http://dx.doi.org/10.1016/j.ccc.2014.12.009 **criticalcare.theclinics.com**
0749-0704/15/$ – see front matter

were major barriers to telemedicine.[2] This article presents the historic developments in the context of proposed solutions with an understanding of the difficulties to achieve a more uniform and easy process to rapidly advance the field of telemedicine.

STATE MEDICAL LICENSURE

There are currently 70 state medical boards in the United States. As required for on-site medical practice, telemedicine is not exempt from obtaining either a full license or a special license to practice in each of the 50 states and territories. Each state issues its own statutes as to how medicine will be practiced, and this is accomplished through each of the state medical boards. Additionally, some states have added special requirements, such as Texas, which has a jurisprudence test, Kentucky has an HIV test, and Mississippi has an on-site open-book test and video to be watched that can be done only in Jackson, Mississippi. The licensing system in the United States has been in existence for more than a century and creates requirements that lack uniformity among all the states. The creation of this model is based on the policing responsibilities of each state, including that for the medical profession. As a result, the state medical boards have taken their responsibility to protect the safety of their citizens as the core mission of how the medical boards regulate the issuance of a license to practice medicine. Unfortunately, with the development of technology such as telemedicine, medical licensure has not adapted to the 21st century and as a result the practice of medicine through telemedicine and across state boundaries has produced a conundrum for health care systems and telemedicine companies in this growing field of medical practice. The citizens of each state, particularly those who live in medically underserved areas, are the ones most often affected by these state regulations and often are required to travel hundreds of miles to seek needed care.

The Beginning: Government and Grants

Interest in telemedicine by both the federal and state governments dates back to the 1990s. In fact, by 1994 there were 18 federal agencies involved in telemedicine, with a budget of $85 million for program development.[3] In 1995, then congressional representative Ron Wyden (D-OR), who is one of the current senators representing Oregon, proposed an amendment to the Communications Act of 1995 to prevent states from restricting interstate telemedicine consultations.[4] This bill was ultimately withdrawn.

The Federation of State Medical Boards (FSMB) has been at the center of many of the nongovernment agencies trying to address the licensure portability issue for years. In 1996, the FSMB adopted a Model Act, which called on state medical boards to adopt a “special-purpose license” to issue limited practice for telemedicine in states beyond where the physician held a current license.[5] The Model Act was adopted by only 8 states.

One year later in 1997, the Office of the Department of Commerce and the Office for the Advancement of Telehealth (OAT), which is a part of the Department of Health and Human Services (HHS), issued a report to Congress identifying licensure as a barrier for telemedicine. Again in 2001, the OAT updated the 1997 report stating again that licensure remains a major barrier to the development of telemedicine.[6]

At about the same time, the National Council of State Boards of Nursing approved a Nurse Licensure Compact in 1998 in which states could agree to recognize a license granted by another participating state. Unfortunately, only 23 states currently have adopted the compact over the course of 16 years.[7]

The FSMB continued to provide leadership, first by establishing, in 2000, a special committee on licensure portability.[5] In 2002, the House Commerce Committee added