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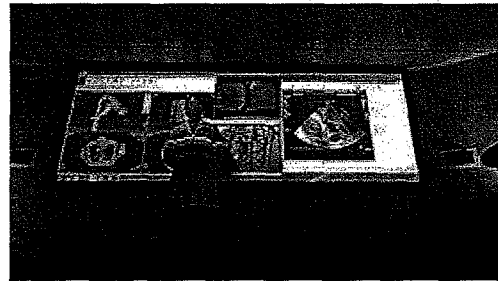
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Proposed patient-centered telemedicine policy raises licensing questions



By [Andis Robeznieks](#)

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The Federation of State Medical Boards will vote next month on a [new telemedicine policy \(PDF\)](#) that codifies that medical care takes place where a patient, not a provider, is located. It also states that whether a [physician](#) and patient have a virtual or a face-to-face encounter, there should be no differences in standards of care.

The proposal carries implications for where doctors practicing [telemedicine](#) need to be licensed. "The practice of medicine occurs where the patient is located at the time telemedicine technologies are used," the proposed policy states. "Physicians who treat or prescribe through online service sites are practicing medicine, and must possess appropriate licensure in all jurisdictions where patients receive care."

Lisa Robin, FSMB chief advocacy officer, said the telemedicine policy actually grew out of an effort to simplify the licensing process for [physicians seeking licenses in multiple states \(PDF\)](#).

But the policy's stand on state license requirements may serve as a barrier, rather than as an aid to telehealth technology expansion, one expert contended.

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Dr. Bart Demaerschalk, professor of neurology and director of telestroke and teleneurology at the Mayo Clinic in Phoenix, said he appreciated the proposed policy's directives to put patient welfare first, adhere to the highest standards of care, protect patients' privacy and securely store their information. But he lamented that the policy "may lack innovative thought" with its insistence that telemedicine doctors be licensed in every state where their patients are located. [Wiring in rural patients](#)

While this is the Mayo Clinic's policy, he explained, it has been an administrative barrier to its program's growth. The clinic currently provides some 3,000 neurology consultations annually to 36 hospitals in 10 states.

The three biggest obstacles to telemedicine's expansion are administrative burdens and time required for state licensing and hospital credentialing; reimbursement; and the cost of technology, Demaerschalk said.

"The most stubborn of all has been the licensing," he added.

Telemedicine barriers could add up to higher costs and poorer outcomes for patients, Demaerschalk said. A recent [Mayo Clinic study](#) appearing in the American Journal of Managed Care found that, compared to a patient in a rural community hospital, patients in a telestroke network incurred costs that were \$1,436 lower.

Demaerschalk suggests the development of a national or multi-state license for telemedicine, or reversing the decision that the medicine is practiced in the patient's physical location.

According to the National Conference of State Legislatures, 43 states and the District of Columbia provide some form of Medicaid reimbursement for primary-care telehealth services, while 19 states and the District of Columbia now require private insurance plans to reimburse providers for telehealth primary-care services. Arizona will join this list in January 2015.

The proposed policy, which will be voted on during the FSMB's annual meeting April 24-25 in Denver, will serve as a model for other state boards to follow and as a guidepost for state legislators and regulators to develop their own telemedicine policies.

Joshua Ewing, an NCSL health policy specialist, said telemedicine is generating significant activity in state capitols.

"Many states are turning to telehealth as a way to address workforce challenges—particularly in rural and underserved areas," Ewing said. "I think many states also feel that telehealth is here, and here to stay. Therefore, they want to make sure they are in front of the issue with proper regulations that ensure patients receive safe, high-quality healthcare that is comparable to that which they would receive in a normal face-to-face interaction with a doctor."

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