Position Statement on Teledermatology

(Approved by the Board of Directors: February 22, 2002; Amended by the Board of Directors: May 22, 2004; November 9, 2013; August 9, 2014; May 16, 2015; March 7, 2016; March 21, 2020; March 20, 2021)

In the event of a public health emergency, access to care is the top priority. As such, individual provisions of this position statement may be temporarily suspended to allow for greater utilization of telemedicine. After the declaration of a public health emergency has been lifted, the position statement on Teledermatology would again apply.

Telemedicine is an innovative, rapidly evolving method of care delivery. The Academy supports the appropriate use of telemedicine as a means of improving access to the expertise of board-certified dermatologists to provide high-quality, high-value care. Telemedicine can also serve to improve patient care coordination and communication between other specialties and dermatology.

Teledermatology is within the scope of the practice of medicine. Board-certified dermatologists have extensive knowledge and expertise in cutaneous medicine, surgery, and pathology. Whether in-person or via teledermatology, the optimal delivery of dermatologic care involves board-certified dermatologists.

Determination of reimbursement for teledermatology services should follow the same process used to value all other codes. This process involves applying recommendations made by the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC). The Academy strongly supports fair and equitable coverage and payment for direct-to-patient and provider-provider consultative telemedicine services provided by board-certified dermatologists when several important criteria are met (see details below in section III). These criteria are essential to ensure that dermatologic care provided by telemedicine is of high quality, contributes to care coordination (rather than fragmentation), meets state licensure and other legal requirements, maintains patient choice and transparency, and protects patient privacy. Patients seeking care delivered via telemedicine should be made aware of their cost sharing responsibility. Additionally, insurers should not require their members to use telemedicine in lieu of an in-person service with a medical provider (or vice-versa).

While teledermatology is a viable option to deliver high-quality care to patients in some circumstances, the Academy supports the preservation of a patient's choice to have access to both in-person dermatology services and teledermatology services when appropriate. There are some skin findings for which an in-person examination, point-of-care testing, or procedures by a dermatologist provide additional information that may not otherwise be obtainable by teledermatology alone.

Teledermatology providers choose between or combine different care delivery platforms (Store-and-Forward, Live-Interactive, and/or Audio Only), each of which has strengths and weaknesses.

I. LIVE-INTERACTIVE TELEDERMATOLOGY

a. Definition

Live-interactive teledermatology takes advantage of videoconferencing as its core technology. Participants are separated in space but interact in real time. By convention, the site where the patient is located is referred to as the originating site and the site where the consultant is located is referred to as the distant site.

b. Technology
A high-resolution video camera is required at the originating site, and a monitor with resolution matched to the camera resolution is required at the distant site. Videoconferencing systems work optimally when a connection speed of >384 kbps is used. Slower connection speeds may necessitate that the individual providing patient images perform either still image capture or freeze frame to render a quality image. For most diagnostic images, a minimum resolution of 800 x 600 pixels (480,000) is required, but higher resolution may increase diagnostic fidelity.

c. Credentialing and Privileging
The Joint Commission (TJC) has implemented standards for telemedicine for practitioners in hospitals and critical access hospitals.

d. Privacy and Confidentiality
Practitioners who practice telemedicine should ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, and its implementing regulations. While live-interactive or store-and-forward transmissions over ISDN infrastructure are thought to be secure, IP transmissions should be encrypted when transmitted over the public internet to ensure security. IP encryption in other settings such as private or semi-private networks is also highly recommended. The handling of records, faxes, and communications utilized in telemedicine is subject to the same HIPAA standards as apply in a standard office environment.

e. Licensing
Interactive telemedicine requires the equivalent of direct patient contact. In the U.S., teledermatology using interactive technologies is restricted to jurisdictions where the provider is permitted, by law, to practice. In other words, the provider using interactive technologies usually must be licensed to practice medicine in the jurisdiction where the patient is located.

f. Current Reimbursement
Medicare reimburses for live-interactive consultations, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system for patients located in non-metropolitan statistical areas (non-MSAs). This includes nearly all rural counties. A definition and listing of qualified areas is available via U.S. Census data at http://www.census.gov/population/metro. In some states, Medicaid reimburses for telemedicine services as well, but many have restrictions. Private insurers vary in their policies, but most will reimburse services provided to patients in rural areas. Not only does it increase access but often can increase quality of care. It is recommended that the provider write a letter of intent to each insurer informing them that the provider will be billing for telemedicine services. For the latest reimbursement information, see the American Telemedicine Association or Centers for Medicare and Medicaid Services websites. The Academy supports efforts to expand Medicare and Medicaid coverage of both live-interactive and store-and-forward telemedicine, without geographic barriers, for patients insured by Federal Health Insurance policies, in Federally Qualified Health Clinics and Indian Health Centers.

g. Responsibility / Liability
If a direct-patient-care-model (provider to patient) is used (no provider at the originating site), the consulting dermatologist bears full responsibility (and potential liability) for the patient's care. The diagnostic and therapeutic recommendations rendered are based solely on information provided by the patient. Therefore, any liability should be based on the information available at the time the encounter was conducted. In a consultative model (provide to provider), liability may be shared with the consulting provider at the originating site; however, the allocation of responsibilities will vary on a case-by case and state-by state

basis. In either case, dermatologists should verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided to patients located across state lines if applicable, prior to the delivery of any telemedicine service.

II. STORE-AND-FORWARD TELEDERMATOLOGY

a. Definitions
Store-and-forward teledermatology refers to a method of providing asynchronous consultations to referring providers or directly to patients. A dermatologic history and a set of images are collected at the originating site and transmitted electronically for review by the dermatologist. In turn, the dermatologist provides guidance to the referring provider or to the patient. Store-and-forward teledermatology can be used in several settings:

1. Teletriage involves the review of patient cases transmitted by a referring provider to determine which patients need to be seen in-person by a dermatologist, which patients can be cared for by teleconsultation, and which patients may not require dermatologic referral.

2. Teleconsultation involves the review of patient cases transmitted by a referring provider and the provision of a consultative report back from the dermatologist to the referring provider. Unless the patient's care is then transferred to the consulting dermatologist, the referring provider typically maintains responsibility for carrying out treatment recommendations.

3. Direct-to-patient teledermatology involves a patient initiating his/her own consultation by transmitting a medical history and images to a dermatologist, who then receives some form of guidance or plan of care from the dermatologist.

b. Technology
A digital camera, whether integrated in a mobile handheld device or comprehensive telecommunications system or a stand-alone product, with a minimum of 800 x 600 pixel (480,000) resolution is recommended; however, higher resolutions may increase diagnostic fidelity. For systems that transmit over the internet, a minimum 128-bit encryption and password-level authentication are recommended.

c. Credentialing and Privileging
Practitioners who render care using store-and-forward systems are viewed by TJC as "consultants" and may not be required to be credentialed at the originating site. However, standards can vary by state and organization.

d. Privacy and Confidentiality
In this case, HIPAA compliance is largely a matter of the originating site informing patients that their medical information and images will be traveling by electronic means to another site for consultation. This should be noted in the consent process at the point of care, and the HIPAA notice of privacy practices. In addition, all electronic transmissions should be encrypted and reasonable care should be taken to authenticate those providers who have electronic access to the telemedicine records.

e. Licensing
Most states require the physician to be licensed in the same state as where the patient resides, even when he or she acts only as a consultant. Providers who wish to provide store-and-forward consultations across state lines should limit such consultations to originating states in which they are permitted, by law, to provide care.
https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf.

f. Current Reimbursement
As of 2014, CMS reimburses store-and-forward teledermatology only as a demonstration project in Hawaii and Alaska. However, several states are currently reimbursing store-and-forward teledermatology for all Medicaid patients. There are also private insurers that are paying for store-and-forward modalities, including those that are part of a Medicare Advantage plan. Providers who wish to provide store-and-forward services should inquire with their payers regarding reimbursement. Store-and-forward teledermatology is an appropriate mode to provide follow-up care for patients that adds convenience and increases access to care for established patients with dermatologic conditions. Therefore, the Academy supports reimbursement coverage for store-and-forward teledermatology similar to live-interactive teledermatology and believes that additional restrictions should not apply.

g. Responsibility / Liability
In the teletriage and teleconsultation models (provider to provider), the referring provider ultimately manages the patient with the aid of the consultant's recommendations. The referring provider may accept the recommendations in part or whole or not at all, and the responsibility and potential liability in this scenario may be shared (between the referring provider and the consultant) based on the extent to which the recommendations were followed by the referring provider. If a direct-to- patient model (provider to patient) is used (no provider at the referring site), the responsibility and potential liability rests entirely on the dermatologist. In this case, the dermatologist would also be responsible to ensure proper follow up and to address any medication complications. Dermatologists should verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

III. AUDIO ONLY TELEDERMATOLOGY

a. Definition of audio only refers to a method of providing real time teledermatology services without the use of photographs or video.

b. While the Academy recognizes the significant limitations of audio only teledermatology, it also acknowledges there are certain circumstances where it may be utilized.

i. When the patient does not have access to technology that allows for the transmission of photographs or video images.

ii. As a means of backup in the event of a disruption in the transmission of visual images or video from the originating site.

iii. When images are not needed such as visits involving the discussion of test results or monitoring of response to treatment among other situations.

IV. CRITERIA for HIGH QUALITY TELEDERMATOLOGY

The Academy supports the use of telemedicine services provided by board-certified dermatologists, as well as coverage and payment for those services, when several important criteria are met:

a. Physicians delivering teledermatology services must be licensed in the state in which the patient receives services and must abide by that state's licensure laws and medical practice laws and regulations. Emergency treatment and situations that arise when a dermatologist's existing patient is traveling to another state should be exceptions to this requirement, though existing laws and regulations may still apply. The Academy supports efforts by State Medical Boards to clarify the exceptions to state licensure pertaining to 1) emergency treatment and 2) when patients are traveling to another state and efforts to facilitate and lower burdens for

physicians to obtain licenses in multiple states or consider telemedicine-specific licensing.

b. Patients or referring physicians seeking teledermatology services must have a choice of a board-certified dermatologist if possible, and at minimum must have access in advance to the licensure and board certification qualifications of the clinician providing virtual care. The delivery of teledermatology services must be consistent with state scope of practice laws. The Academy strongly believes that any use of non- physician clinicians in the delivery of teledermatology should abide by the supervision requirements in the Academy's Position Statement on the Practice of Dermatology.

c. The patient's relevant medical history must be collected as part of the provision of teledermatology services. For teletriage and teleconsultation, necessary medical records should be available to the consulting dermatologist prior to or at the time of the telemedicine encounter. Consulting dermatologists should have a good understanding of the culture, health care infrastructure, and patient resources available at the site from which consults are originating.

d. The provision of teledermatology services must be properly documented. These medical records should be maintained at the consultant site, and for teletriage and teleconsultation services, should also be available at the originating site.

e. The provision of teledermatology services should, when needed, include care coordination with the patient's existing primary care physician or medical home, and existing dermatologist if one exists. In some cases, it will be necessary to provide information about diagnoses, test results, and medication changes to the patient's existing care team.

f. Organizations and clinicians participating in teledermatology should have an active training and quality assurance program for both the originating and consultant sites. In addition, those originating sites that are using teledermatology should have documentation of their training programs for any technician who is capturing clinical images and for any manager who is facilitating consults. Each organization should also maintain documentation on how the program protects patient privacy, promotes high quality clinical and image data, supports continuity of care, and ensures care coordination for patients who may require subsequent in-person evaluations or procedures.

g. Organizations and clinicians participating in teledermatology should refer patients needing rapid in-person medical attention to local urgent and emergency medical facilities.

h. The physician-patient relationship:

    a. For teletriage and teleconsultation services where a referring provider ultimately manages the patient (including the prescription of medications), the consulting dermatologist is **not** required to have a pre-existing, patient-physician relationship. It is optimal, however, that the patient has access to in-person follow-up with a local, board-certified dermatologist if needed.

    b. For direct-to-patient teledermatology, the Academy believes that the consulting dermatologist should optimally:

        i. Have an existing physician-patient relationship (having previously seen the patient in- person), or

        ii. Establish a physician-patient relationship through the use of a live-interactive consultation before the use of store-and-forward or audio only technology, or

iii. Have access to the patient's past and current medical records to enable care coordination and follow-up care as needed.

i. The use of ***direct-to-patient teledermatology*** raises several additional issues (and all of the above criteria still apply):

a. Providers must exercise caution regarding direct prescribing for patients cared for using only electronic communications and should familiarize themselves with state regulations. States may have regulations that discourage or prohibit practitioners from prescribing for patients that they have never seen in-person. In many cases, the wording of these regulations is such that a live-interactive teleconsultation would meet the requirements for a "face to face exam." The Federation of State Medical Boards established a National Clearinghouse on Internet Prescribing located at http://www.fsmb.org/ncip_overview.html. The Clearinghouse includes a state-by-state breakdown of jurisdiction, regulations, and actions related to the regulation of Internet prescribing of medications.

b. Dermatologists providing direct-to-patient teledermatology must make every effort to collect accurate, complete, and high-quality clinical information. When appropriate, the dermatologist may wish to contact the primary care providers or other specialists to obtain additional corroborating information.

c. Photographs obtained by patients, their family members, or other associated persons outside of a clinical setting may not be of adequate quality, or may not include the appropriate lesions or areas, to make an accurate diagnosis.

Mechanisms to facilitate continuity of care, follow-up care, and referrals for urgent and emergency services in the patient's geographic area should be in place.

d. The AAD believes that when creating directories of participating physicians or establishing network adequacy, an insurer should not consider telehealth access as a substitute for locally available dermatologists who can provide in-person care and offer the full spectrum of medical and surgical care for skin diseases.

e. The Academy supports teledermatology services designed and dedicated to consistently provide demonstrably high-quality patient care.

f. The Academy does not support teledermatology services that offer easy prescriptions without an adequate history, examination and proper patient-provider relationship.

g. The Academy supports transparency including but not limited to all business models that discount teledermatology services as a way to reduce utilization of other medical services or retail services offered by that business.

h. The Academy opposes attempts to restrict teledermatology to narrow networks of providers.

i. The Academy does not support teledermatology services that prioritize business interests over the quality and safety of patient care.

V. TELEHEALTH POLICY POST COVID-19

The Academy supports the study of the waivers on telehealth provided by CMS and followed by most private insurers during the COVID-19 public health emergency (PHE). The Academy supports:

a. A quantitative analysis of the use of telehealth services and programs during the PHE including data points on use by underserved and marginalized populations.

b. An analysis of the public health impacts of those actions during the PHE and the potential future impact.