Position on Telemedicine for Dermatologic Surgeons

Support:

- Access to quality care from a board-certified dermatologist both in-person and using telemedicine as warranted.
- Fair reimbursement for telemedicine, understanding that in-person care is preferred and able to diagnose more complex issues.
- An existing patient-physician relationship to optimally utilize telemedicine.
- Offering telemedicine in specialist shortage areas and for chronic conditions.
- Liability protection for physicians providing telemedicine and in person care during public health emergencies (PHEs).

Oppose:

- Telemedicine when a doctor-patient relationship has not been established or is not possible due to established shortages of board-certified dermatologists.
- Direct access to medical care by non-physician providers via telemedicine unless direct oversight by a physician is provided.

Telemedicine is not equal to an in-person evaluation by a board-certified dermatologist. While telemedicine helps to fill crucial gaps during the COVID-19 PHE, it does not serve as equal substitution. In-person patient encounters by a board-certified dermatologist are the gold standard for dermatology diagnosis. Telemedicine may be helpful for board-certified dermatologists for triage and follow up. During PHEs, telemedicine can temporarily fill a gap in care by allowing patients to see and communicate with their physician and there is no doubt that flexibilities related to telemedicine can maintain a baseline of care until patients may safely see their physicians. Likewise, telemedicine should be reimbursed at a level that is commensurate with the care provided; in-person care from a physician is more time-intensive and allows the physician to be able to do a full evaluation of the patient. States that have private payer parity laws disregard the complexity, time and follow up that does not always occur with a telemedicine visit.[i]

Telemedicine does not serve the best interest of patients when they virtually see a dermatologist who is unfamiliar with their history and presenting complaint. It is entirely possible that during PHEs, an individual may find a mole they think is concerning and require a biopsy or develop a skin disease that may require a prescription. Attempting to use video technology or sending photos to a dermatologist is not a replacement for in-person care.[ii] In-person visits by a dermatologist are the gold standard to find and diagnose skin conditions that are benign, serious or malignant. Telemedicine should only be used in dermatology when a doctor-patient relationship has already been established.

Those with chronic conditions or who live in areas with a shortage of specialists should have the option to utilize telemedicine. After a doctor-patient relationship has been established, telemedicine serves the dual purpose of allowing patients to check in frequently with their dermatologist without making long trips to a doctor's office. A dermatologist can monitor a chronic condition via telemedicine by discussing any changes in the patient's condition. A doctor-patient relationship that begins with an in-person encounter allows a dermatologist to be intimately familiar with the patient and makes the use of telemedicine to monitor the condition safer and more effective.[iii] If clinically appropriate, those with chronic conditions or in areas of specialist shortages should be able to utilize telemedicine.

Non-physician providers are not a substitute for board-certified dermatologists. Physicians have much more advanced training than physician assistants, nurse practitioners and other non-physician providers, although we understand their contribution to the medical care of patients. The delivery of telemedicine services must be consistent with state scope of practice laws. Additionally, patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit. Multiple studies have shown greater accuracy of board-certified dermatologists performing telemedicine compared to non-dermatologists.[iv] Any physician supervision state laws must be followed, even in a virtual setting, and providers should not provide care that is outside their scope of practice.[v] [vi]

Approved by the ASDSA Board of Directors: February 2021

[i] Federation of State Medical Boards Telemedicine Policies: Board by Board Overview. Accessed September 24, 2020. https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf

[ii] Bastola M, Locatis C, Fontelo P. Diagnostic Reliability of In-Person Versus Remote Dermatology: A Meta-Analysis. Telemed J E Health. 2020 Jul 8. doi: 10.1089/tmj.2020.0043. Epub ahead of print. PMID: 32639856.

[iii] Building a Modern Healthcare System. Accessed Nov. 1, 2020. https://www.ehidc.org/sites/default/files/resources/files/Building%20a%20Modern%20Health%20Care%20System%20FIN1.pdf

[iv] Resneck J S, Abrouk M, Steuer M, Tam A et al. Choice, Transparency, Coordination, and Quality Among Direct-to- Consumer Telemedicine Websites and Apps Treating Skin Disease. JAMA Derm 2016:152:768-775.

[v] American Medical Association 50-state survey: Establishment of a patient-physician relationship via telemedicine. Accessed September 24, 2020. https://www.ama-assn.org/system/files/2018-10/ama-chart-telemedicine-patient-physician-relationship.pdf

[vi] ASDSA Position Statement on Delegation. Accessed September 24, 2020. https://www.asds.net/Portals/0/PDF/asdsa/asdsa-position-statement-delegation.pdf

Related AMA Policy:

Code of Medical Ethics
1.2.12 Ethical Practice in Telemedicine

Innovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another.

Telehealth and telemedicine span a continuum of technologies that offer new ways to deliver care. Yet as in any mode of care, patients need to be able to trust that physicians will place patient welfare above other interests, provide competent care, provide the information patients need to make well-considered decisions about care, respect patient privacy and confidentiality, and take steps to ensure continuity of care. Although physicians' fundamental ethical responsibilities do not change, the continuum of possible patient-physician interactions in telehealth/telemedicine give rise to differing levels of accountability for physicians.

All physicians who participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental fiduciary obligations by disclosing any financial or other interests the physician has in the telehealth/telemedicine application or service and taking steps to manage or eliminate conflicts of interests. Whenever they provide health information, including health content for websites or mobile health applications, physicians must ensure that the information they provide or that is attributed to them is objective and accurate.

Similarly, all physicians who participate in telehealth/telemedicine must assure themselves that telemedicine services have appropriate protocols to prevent unauthorized access and to protect the security and integrity of patient information at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who participate in the telehealth/telemedicine service consistent with their individual roles.

Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:

(a) Inform users about the limitations of the relationship and services provided.

(b) Advise site users about how to arrange for needed care when follow-up care is indicated.

(c) Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.

Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:

(d) Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.

(e) Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patient's site conduct the exam or obtaining vital information through remote technologies.

(f) Be prudent in carrying out a diagnostic evaluation or prescribing medication by:

(i) establishing the patient's identity;

(ii) confirming that telehealth/telemedicine services are appropriate for that patient's individual situation and medical needs;

(iii) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and

(iv) documenting the clinical evaluation and prescription.

(g) When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options.

Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.

(h) As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients' preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patient's primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient.

Collectively, through their professional organizations and health care institutions, physicians should:

(i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.

(j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.

(k) Routinely monitor the telehealth/telemedicine landscape to:

(i) identify and address adverse consequences as technologies and activities evolve; and

(ii) identify and encourage dissemination of both positive and negative outcomes.

AMA Principles of Medical Ethics: I, IV, VI, IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

D-295.313 Telemedicine in Medical Education

1. Our AMA encourages appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations.

2. Our AMA will collaborate with appropriate stakeholders to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals.

3. Our AMA encourages the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to include core competencies in telemedicine in undergraduate medical education and graduate medical education training.
(CME Rep. 06, A-16)

D-480.964 Established Patient Relationships and Telemedicine

Our AMA will: (1) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services; (2) advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Interstate Medical Licensure Compact; and (3) work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services, in accordance with AMA Policy H-480.946, "Coverage of and Payment for Telemedicine."
(CMS Rep. 1, I-19)

D-480.968 Telemedicine Encounters by Third Party Vendors

1. Our AMA will develop model legislation and/or regulations requiring telemedicine services or vendors to coordinate care with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and/or treating physicians and providing to the treating physician a copy of the medical record, with the patient's consent.

2. The model legislation and/or regulations will also require the vendor to abide by laws addressing the privacy and security of patients' medical information

3. Our AMA will include in that model state legislation the following concepts based on AMA policy: (a) A valid patient-physician relationship must be established before the provision of telemedicine services; (b) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (c) The standards and scope of telemedicine services should be consistent with related in-person services.

4. Our AMA will educate and advocate to AMA members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients. (Res. 234, A-16)

D-480.969 Insurance Coverage Parity for Telemedicine Service

1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover

telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.

2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.

3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.
(Res. 233, A-16; Reaffirmed: CMS Rep. 1, I-19)

D-480.970 Access and Equity in Telemedicine Payments

Our AMA will advocate that the Centers for Medicare & Medicaid Services pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined shortage areas, if that area can show a shortage of those physician specialists. (Res 818, I-14; Reaffirmed: CME Rep. 06, A-16)

D-480.974 Professionalism in Telemedicine and Telehealth

The Council on Ethical and Judicial Affairs will review Opinions relating to telemedicine/telehealth and update the Code of Medical Ethics as appropriate.
(BOT Rep. 22, A-13)

D-480.999 State Authority and Flexibility in Medical Licensure for Telemedicine

Our AMA will continue its opposition to a single national federalized system of medical licensure.
(CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)

H-160.937 The Promotion of Quality Telemedicine

1. The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used:

    A. The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine.

    B. Physician supervision (e.g. regarding protocols, conferencing, and medical record review) is required when nonphysician providers or technicians deliver services via telemedicine in all settings and circumstances.

C. Physicians should visit the sites where patients receive services from nonphysician providers or technicians through telemedicine and must be knowledgeable regarding the competence and qualifications of the nonphysician providers utilized.

D. The supervising physician should have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting.

E. Nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services.

F. The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services.

G. Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, nonphysician providers, and technicians.

H. The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving nonphysician providers or technicians.

2. The AMA urges those who design or utilize telemedicine systems to make prudent and reasonable use of those technologies necessary to apply current or future confidentiality and privacy principles and requirements to telemedicine interactions.

3. The AMA emphasizes to physicians their responsibility to ensure that their legal and ethical requirements with respect to patient confidentiality and data integrity are not compromised by the use of any particular telemedicine modality.

4. The AMA advocates that continuing medical education conducted using telemedicine adhere to the standards of the AMA's Physician Recognition Award and the Accreditation Criteria of the Accreditation Council for Continuing Medical Education.

5. Our AMA supports the appropriate use of telemedicine in the education of medical students, residents, fellows and practicing physicians.
(CME/CMS Rep., I-96; Reaffirmed: CMS Rep. 8, A-06; Modified: CMS Rep. 01, A-16; Appended: CME 06, A-16)

H-225.962 Medical Staff Membership Category for Physicians Providing Telemedicine

The AMA recommends that organized medical staffs, as part of their responsibility for the quality of professional services provided by individuals with clinical privileges, identify to the governing body of the hospital/medical care organization those clinical services that can be provided by telemedicine; and recommends that organized medical staffs (a) amend the medical staff bylaws to allow physicians providing telemedicine to be granted and maintain medical staff membership if they meet other obligations of such membership and (b) incorporate Policy 160.937, regarding their responsibility for supervision of non-physician providers and technicians delivering services via telemedicine, in the medical staff bylaws or rules and regulations.
(BOT Rep. 3, A-97; Reaffirmed: CLRPD Rep. 2, A-07; Reaffirmed: BOT Rep. 22, A-13)

H-480.946 Coverage of and Payment for Telemedicine

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:

a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:

- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
- Meeting standards of establishing a patient-physician relationship included as part of evidence- based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.

c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services or be providing these services as otherwise authorized by that state's medical board.

d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.

e) The delivery of telemedicine services must be consistent with state scope of practice laws.

f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.

g) The standards and scope of telemedicine services should be consistent with related in-person services.

h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.

i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.

j) The patient's medical history must be collected as part of the provision of any telemedicine service.

k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.

l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.

m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.

4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.

5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.

6. Our AMA encourages physicians to 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.

7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.
(CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmation: A-18; Reaffirmed: CMS Rep. 1, I-19)

H-480.961 Teleconsultations and Medicare Reimbursement

Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes.
(Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed in lieu of Res. 806, I-12)

H-480.968 Telemedicine

The AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects

of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery. (Res. 117, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16)

H-480.969 The Promotion of Quality Telemedicine

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

(a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state;

(b)) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation;

(c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and

(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.

(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties).

(CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I- 14; Reaffirmed: CMS Rep. 1, I-19)

H-480.974 Evolving Impact of Telemedicine

Our AMA:

(1) will evaluate relevant federal legislation related to telemedicine;

(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;

(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;

(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;

(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;

(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;

(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;

(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and

(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (*www.americantelemed.org*) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.
(CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18)