DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO
ATTENTION OF

DASG-IM

OTSG/MEDCOM Policy Memo 04-006

18 JUN 2004

Expires 18 June 2006

MEMORANDUM FOR

Commanders, MEDCOM Major Subordinate Commands/Activities/Installations
Directors, OTSG/MEDCOM One Staff

SUBJECT: Use of Telehealth in AMEDD Medical Units

1. References:

a. MEDCOM Regulation 25-1, Information Management, 9 Sep 02 (Revision pending).

b. Medical Records Administration and Health Care Documentation AR 40-66, 10 Mar 03.

c. Interim Policy for Business Process Change for Custody and Control of Outpatient Records. OTSG/MEDCOM Policy Memo 03-006, 28 Aug 03

d. Clinical Quality Management AR 40-68, 26 Feb 04.

e. The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

f. DA Policy on LANS and Wireless Portable Electronic Devices (PEDs) of 15 April 02.

2. Purpose. To state the policy for the use of telehealth services within the Army Medical Department (AMEDD) TDA facilities.

3. Proponent. The proponent for this policy is Health Policy and Services (HP&S) Directorate.

4. Responsibilities.

a. Regional Medical Command (RMC) Staff and MTF Command Staff are responsible for the Telehealth Administration and implementation of AMEDD policy.

b. RMC and MTF Consultants and designated Telehealth functional proponent are responsible for selecting clinical services for Telehealth practice based on a Business Case Analysis (BCA).

c. MTF healthcare providers are responsible for maintaining appropriate medical standards when using Telehealth to deliver healthcare services to beneficiaries.

5. Definitions.

a. **Telehealth,** a subset of e-Health, is a component of a complete healthcare system since it supports standard clinical practice through the use of information technology and telecommunications to link critical resources, deliver care to patients that would otherwise not have reasonable access to a particular healthcare service, and provide enhanced educational opportunities for patients and professionals.

b. **Teleconsultation** is the use of Telehealth to obtain standard and currently approved forms of healthcare consultation between healthcare providers in a medical-legal form for medical record archival. A teleconsultation is not a telephone consultation (TCON) between providers or a traditional patient referral whereby the patient's care is transferred to the Consultant. The use of patient-to-provider or provider-to-provider email will be addressed in a subsequent OTSG policy memorandum. Teleconsultation is becoming a standard form of business in large healthcare systems since it uses the technology to optimize the access to important medical, surgical, or allied-healthcare specialty information, and is expected to become a larger part of future AMEDD business.

6. Policies.

a. Telehealth will be utilized when it augments, expands, or enhances the delivery of healthcare services across the MHS.

b. The analysis of Telehealth follow the IAW the BCA procedures to select clinical services and to monitor future performance metrics.

c. Non-research based uses of Telehealth will be brought through the MEDCOM 25-1 process defined in Reference 1a above.

d. When Telehealth is utilized by a RMC and MTF, Commanders will ensure that:

(1) Healthcare personnel are trained, knowledgeable, and have the capacity to use telehealth as part of their clinical practice where appropriate.

(2) Administrative personnel are trained, knowledgeable, and have the capacity to use telehealth as part of their clinical practice where appropriate.

(3) Performance metrics are embedded to support the BCA and reported to MTF and RMC Quality Management Boards.

(4) The RMC and MTF conducts annual reviews of all Telehealth programs as part of their BSC requirement.

e. Telehealth capabilities can be used for Resource Sharing Agreements between VA/DOD and Academic Universities whenever it supports the BCA. Before Telehealth services are exchanged a formal Resource Sharing Agreement is required.

7. Medical Documentation.

a. All Telehealth and Teleconsultations will be archived in the medical record on a printed SF 513 or SF 600 in addition to other digital-database formats.

b. Medical information generated from Telehealth will be part of the medical record in the facility rendering the service or healthcare (References 1b and 1c). Clarifications relative to the collection of non-standard items in the permanent out-patient medical record will be addressed in a subsequent OTSG policy memorandum.

c. Teleradiology will use standard radiology report forms in addition to PACS.

d. Healthcare encounters using video-teleconferencing (VTC) system will only be recorded after appropriate informed consent and then used for medical education or approved clinical investigation purposes only. If video-archival is performed, the information must be preserved as part of the medical record at the facility delivering the healthcare or service in accordance with DoD medical records policy.

8. Quality Management.

a. AR 40-68, Clinical Quality Management (Reference 1d), and standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will be supported in all Telehealth programs.

b. When Telehealth performance metrics exceed JCAHO standards, AR 40-68 guidelines must be followed. See the attached implementation Annex for more specific guidance.

9. Workload Accounting and Coding. MHS legacy administration and workload accounting systems do not support Telehealth coding and practices currently. However, system change requests have been submitted to include all CPT modifiers which would enable transformation of current accounting practice and enable better implementation of Telehealth. Additional guidance relative to coding and workload accounting for Telehealth will be provided via a subsequent OTSG policy memorandum. See the implementation Annex attached for interim guidance.

10. Informed Consent. Telehealth encounters require informed consent before any use of the system can occur. It is the responsibility of health care provider to obtain the written and informed consent of a patient prior to use of the technology. It is the responsibility of the consultant and the MTF and RMC to ensure that the content of the informed consent is

complete and accurate. All written informed consent will be maintained in the patient's legal medical record. Commanders are authorized to develop a suitable overprint of 522 (Medical Record- Request for Administration of Anesthesia and for Performance of Operations and Other Procedures) to document patient consent for this purpose. If the facility is in a State that mandates a specific consent form, the Federal government recognizes the State-mandated Form. The Interagency Committee on Medical Records is actively working on this issue, and will announce changes in an updated AR 40-66.

11. Information Security. HIPPA requirements dictate the standards for all electronic patient information to include those of Telehealth. Guidance on HIPPA standards can be obtained from the MTF or RMC Quality Management Board who are the Command official representatives.

12. Regulation Compliance. MHS is a covered entity as defined by HIPAA of 1996 and such telehealth must comply with HIPAA TRANSACTIONS AND CODE SET, IDENTIFIER, Privacy, and SECURITY STANDARDS (TIPS) as they evolve per Reference 1e.

13. Changes to policy. Submit recommendations for a change to this policy on DA Form 2028, Recommended Changes to Publications and Blank Forms, to Commander, U.S. Army Medical Department Center and School, ATTN: MCCS-HR, 3151 Scott Road, Suite 1408, Fort Sam Houston, TX 78234-6135.

14. POC. The point of contact for this Policy Memorandum is COL Ron Poropatich, OTSG Telehealth Consultant at (202) 782-7908, DSN 662-7908 or at email ron.proropatich@na.amedd.army.mil. The Telehealth Program Office, USAMRMC, will serve as the management and resource center for all Telehealth issues.

FOR THE COMMANDER:

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KENNETH L. FARMER, JR.
Major General
Chief of Staff

Annex

The following information is provided as supplemental guidance to support the adoption and implementation of Telehealth practices.

1. Definitions.

a. **EHealth.** The application of electronic technologies to improve the delivery, access, education, administration, and coordination of standard healthcare services.

b. **Telemedicine,** a subset of telehealth, is the use of information and telecommunications technologies to electronically organize and distribute healthcare information between privileged providers (only) for purposes of obtaining advice or an opinion, diagnosis or study interpretation or to provide direct care between a provider and a patient. It also can include remote medical monitoring to support in-patient or out-patient care. Telemedicine has historically been oriented to a medical-centric model and has for the most part not included clinical services provided by other types of healthcare providers. Examples of telemedicine include teleradiology, telepathology, teledermatology etc.

2. Teleconsultation Modalities. Teleconsultation may be conducted between two healthcare providers either by store-forward or video-teleconferencing methods.

a. Store-Forward (S & F) is the use of asynchronous or delayed transmission of medical information from one provider to another provider to be reviewed at a later time. The provider at the distant site reviews the case on behalf of the consulting provider without the patient being present.

b. Video-Teleconferencing (VTC) is the use of synchronous or live telecommunications for two-way, real-time exchange of provider-to-provider or patient-to-provider information.

3. Telehealth Applications. Telehealth practices are expected to expand in scope, frequency and utility for number of healthcare services. For example:

a. Teleproctoring is the use of VTC or synchronous live telecommunications for the purpose of professional oversight or mentoring. This method is most often conducted between a less-skilled provider and an expert for purposes of guidance during a surgical or medical procedure.

b. Telehomehealth is the application of telehealth to deliver disease management and/or social services to individuals who are chronically ill or disabled at home.

4. Data Standards.

a. NIST, UMLS, SNOMED-CT, ICD-9, ICD-10, etc.

b. CHCSII.

5. Clinical Protocols and Guidelines. National, Federal, and State guidelines and Standards of Practice will be utilized, where applicable, in the implementation of Telehealth systems and the collection of clinical data and information.

a. Clinical Protocols and Guidelines/Military Unique: Medical/Dental Consultants (both primary care and specialty care) will develop clinical data requirements for Teleconsultation either by a given clinical specialty or medical condition as appropriate for MHS systems. These protocols and referral guidelines will be utilized in current systems and eventually incorporated into CHCS II.

b. All guidelines and protocols will be referenced to include clinical investigation protocols as part of the medical record and electronic archived record.

c. Image Standards will be monitored and reported as part of the Performance Measures is applicable.

6. System Requirements.

a. Telehealth systems currently use the standards built into MTF and RMC networked systems under MTF and RMC IM/IT. Every effort should be made to standardize Telehealth systems across the AMEDD. Standardization reduces training requirements, increases user acceptance and decreases the overall costs of operation and life-cycle maintenance. Standardization further ensures uniformity of data and provides quality controls. This also eliminates the possibility of configuration or data exchange incompatibilities.

b. Any device that is connected to a MHS networked system must be approved by the MTF or RMC IM/IT prior to connection to the network.

c. Telehealth systems must be designed to function successfully within a low bandwidth environment, be easy to use and responsive to the performance requirements of the end-user.

d. Telehealth systems must utilize to the maximum extent possible, existing file format standards such as DICOM, HL-7, JPEG, MPEG etc., rather than proprietary formats.

e. Telehealth systems should be capable of integrating with enterprise architecture.

7. Clinical Business Process. Teleconsultations will incorporate performance metrics that assist the BCA such as turn-around time, change in diagnosis, cost-savings through cost avoidance and improvement in clinical outcome.

8. Quality Management.

a. Providers who write orders, or direct care, treatment or services via telemedicine must be privileged at the facility receiving the service. This may be accomplished by use of the Inter-facility Credentials Transfer Brief (ICTB) along with a copy of the provider's delineation of privileges. The MTF receiving the service should privilege the provider only for the services they will be receiving. Types of services requiring privileges at the receiving facility include, but are not limited to, any telemedicine services which involve VTC or other direct interactions between patient and provider.

b. Providers who provide official readings of images, tracings or specimens or who provide only consultative advice do not require privileges at the receiving MTF. In such cases, the MTF must obtain and maintain a copy of the ICTB and delineation of privileges from the providers home MTF, but need not privilege the provider. Examples of these types of services include, but are not limited to, teleradiology (except mammography which has additional requirements), teleechocardiography, telepathology, and store-forward teledermatology.

c. These credentialing and privileging requirements do not apply when the receiving facility or provider is deployed to a theater of operations.

d. The RMC and MTF Quality Management Board are responsible for implementation of AMEDD policy and meeting JCAHO standards of practice. The credential issues are expected to change and encompass service-wide credentialing and privileges as a priority for Readiness. Check with your local QMB on the current standards at your facility.

9. Workload Accounting and Coding Practices. Telehealth practices are rapidly changing and are anticipated to be modified frequently. Check with your local Quality Management Board on the current standards and updates that expand coding and accounting for Telehealth practice.

- Consultations (CPT codes 99241-99275)
- Office or other out-patient visits (CPT codes 99201-00215)
- Individual psychotherapy (CPT codes 90804-90809)
- Pharmacologic management (CPT code 90862)

Reference: Section 15516, Medicare Payment for Telehealth Services. Medicare Carriers Manual, Part 3 Claims Process, Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS), Publication 14-3, and Revision 1798, dated May 16 2003.