

# A CALL TO ACTION: GEORGIA MUST ADOPT NEW STANDARD OF CARE, LICENSURE, REIMBURSEMENT, AND PRIVACY LAWS FOR TELEMEDICINE

## INTRODUCTION

Information technology has the potential to expand, reduce the costs of, increase the quality of, and modernize healthcare. Healthcare costs in the United States are among the highest in the world and are increasing in spite of modifications in healthcare organization and financing.<sup>1</sup> In 2004, healthcare spending in the United States totaled \$1.55 trillion.<sup>2</sup> “Forty-five million Americans either have no health insurance or are significantly underinsured,” and geographic barriers limit access to care for many others.<sup>3</sup> For those without healthcare due to geographic barriers, telemedicine may enable access.<sup>4</sup> Further, the implementation of telemedicine could save an estimated \$15 to 20 billion per year.<sup>5</sup>

Telemedicine is also a promising solution to medical errors. According to the Institute of Medicine, two of the most common types of preventable errors are inaccurate diagnosis and failure to prevent injury.<sup>6</sup> In localities where

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<sup>1</sup> See Robert Pear, *Health Spending Rises to 15% of Economy, a Record Level*, N.Y. TIMES, Jan. 9, 2004, at A16. According to the Department of Health and Human Services, healthcare costs increased 9.3% in 2002. *Id.* This increase was the largest in eleven years, and an estimated 17.7% of the gross domestic product will be spent on healthcare by the year 2012. *Id.*

<sup>2</sup> *Id.*

<sup>3</sup> PRESIDENT’S INFORMATION TECHNOLOGY ADVISORY COMMITTEE PANEL ON TRANSFORMING HEALTH CARE, *TRANSFORMING HEALTH CARE THROUGH INFORMATION TECHNOLOGY 2* (2001), available at <http://health.internet2.edu/files/pitac-hc-9feb01.pdf>.

<sup>4</sup> The Institute of Medicine estimates that medical errors contribute to at least 44,000—and as many as 98,000—deaths, even the lower estimate of which is more than AIDS, breast cancer, or motor-vehicle accidents. INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1* (2000).

<sup>5</sup> *VA Health Care: Communication and Information Technologies and Related Issues: Hearing Before the Subcomm. on Oversight and Investigations of the House Comm. on Veterans’ Affairs*, 103d Cong. 46 (1994) (statement of Michael D. McDonald, senior advisor on health and telecommunications, C. Everett Koop Institute). Dr. Eric Tangalos of the Mayo Clinic stated that “the export of U.S. medical expertise” could “fund our domestic health care system” with the use of telemedicine. Stacey Swatek Huie, Note, *Facilitating Telemedicine: Reconciling National Access with State Licensing Laws*, 18 HASTINGS COMM. & ENT. L.J. 377, 392 (1996).

<sup>6</sup> Medical errors, such as failure to screen for potential drug interactions, occur most often in intensive care units, operating rooms, and emergency departments. INSTITUTE OF MEDICINE, *supra* note 4, at 1.

specialists are scarce, primary care providers can use telemedicine to consult specialists in any state, enabling them to receive a second opinion and better prevent these errors during both diagnosis and treatment.

Georgia expanded its citizens' healthcare access when it became a national leader in the telemedicine movement in the early 1990s.<sup>7</sup> However, Georgia's present laws do not facilitate telemedicine's progress. In fact, they impede it. Georgia must address its existing telemedicine policies and modify them to again lead the nation in the advancement of telemedicine.

This Comment proposes that Georgia must change its current approach toward telemedicine to stay at the forefront of telemedicine development. To achieve this end, Georgia must advocate a national standard of care for telemedicine practitioners, liberalize its current licensure standards, oversee and promote public and private insurer reimbursement for telemedicine, and enact legislation to ensure the privacy of patient information used in telemedicine. Part I of this Comment defines telemedicine and discusses its past and present uses. Part II provides a detailed description of the development and impact of Georgia's telemedicine movement, including recent initiatives in Georgia. Part III compares Georgia's approach to standard of care, licensure, reimbursement, and privacy issues to the approaches of a number of other states. Finally, the Comment concludes by suggesting means to improve the quality of and access to healthcare via telemedicine, both in Georgia and throughout the United States.<sup>8</sup>

## I. BACKGROUND OF TELEMEDICINE

The World Health Organization defines telemedicine as:

The delivery of health care services, where distance is a critical factor, by health care professionals using information and communications technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health

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<sup>7</sup> Medical College of Georgia, Center for Telehealth, Evolution of the Georgia Statewide Telemedicine Program, at <http://www.mcg.edu/telehealth/Evolution.htm> (Apr. 13, 2004).

<sup>8</sup> Taking a progressive stance will help telemedicine grow within Georgia's borders and beyond because other states will likely follow Georgia's example due to Georgia's status as a national leader in telemedicine. See *supra* note 7 and accompanying text.

care providers, all in the interest of advancing the health of individuals and their communities.<sup>9</sup>

In other words, telemedicine consists of using remote transmissions of video, audio, and text data to provide information to individuals involved in a patient's care.<sup>10</sup> Telemedicine is wide ranging in both its applications—from “transporting medical data over the phone or fax machines” to applying “interactive video conferencing using satellite or fiber optic technology”<sup>11</sup>—and its benefits.<sup>12</sup>

Telemedicine must be distinguished from cybermedicine and telehealth. While cybermedicine also involves the distribution of health information, it is communication conducted on an Internet site without a previous or ongoing doctor-patient relationship.<sup>13</sup> Telehealth requires a broader utilization of electronic transmissions than telemedicine and consists of using “electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.”<sup>14</sup>

Telemedicine began in the 1950s when the National Institute of Mental Health established a closed-circuit telephone system to connect seven state hospitals in four states.<sup>15</sup> During the space program in the 1960s, NASA began

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<sup>9</sup> WORLD HEALTH ORGANIZATION DEPARTMENT OF ESSENTIAL HEALTH TECHNOLOGIES, INFORMATION TECHNOLOGY IN SUPPORT OF HEALTH CARE 1, at <http://www.who.int/eht/en/InformationTech.pdf> (last visited Apr. 28, 2005). Consistent with the World Health Organization's definition, the American Telemedicine Association defines telemedicine as “the use of medical information exchanged from one site to another via electronic communications to improve patients' health status.” The American Telemedicine Association, *Defining Telemedicine*, at <http://www.atmeda.org/search/search.htm> (last visited Apr. 29, 2005).

<sup>10</sup> In the context of this paper, use of the term “telemedicine” invokes any of these forms of transmission.

<sup>11</sup> See Barbara K. Boxer, *Telemedicine: Overcoming the Legal Issues Surrounding Telemedicine or Allowing Physicians to Charge for Phone Calls*, HEALTH LAW., May 1998, at 18, 18.

<sup>12</sup> A study conducted between 1966 and 1996 revealed that telemedicine technologies are beneficial in the areas of preventive care and the management of diabetes care and cardiac rehabilitation. INSTITUTE OF MEDICINE, *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* 166 (2001).

<sup>13</sup> Ross D. Silverman, *Regulating Medical Practice in the Cyber Age: Issues and Challenges for State Medical Boards*, 26 AM. J.L. & MED. 255, 264–67 (2000) (discussing the history of cybermedicine and its issues); see also Shira D. Weiner, Note, *Mouse-To-Mouse Resuscitation: Cybermedicine and the Need for Federal Regulation*, 23 CARDOZO L. REV. 1107, 1113–14 (2002) (discussing the practices of cybermedicine and telemedicine). Information exchanged via cybermedicine occurs when “patients submit information regarding symptoms and ailments and cyberdoctors respond with general information, medical advice or diagnoses regarding illnesses.” *Id.* at 1114.

<sup>14</sup> U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *TELEMEDICINE REPORT TO CONGRESS I* (2001).

<sup>15</sup> Douglas D. Bradham et al., *The Information Superhighway and Telemedicine: Applications, Status, and Issues*, 30 WAKE FOREST L. REV. 145, 149 (1995).

employing telemetric technologies by transmitting voice and data via satellite to monitor the health of astronauts in space.<sup>16</sup> In the following decade, NASA, the Indian Health Service, and the Papago Indian Tribe used mobile health providers who transferred data from a remote reservation to a distant hospital, and a separate NASA program in Alaska used satellites to enable local providers to correspond with distant physicians.<sup>17</sup>

Initially, most telemedicine programs relied on interactive video to connect rural inhabitants with urban medical specialists.<sup>18</sup> Over time, these programs became more widespread as technological advances enabled more sophisticated applications of telemedicine, including telepresence surgery,<sup>19</sup> electronic patient records,<sup>20</sup> smart cards,<sup>21</sup> and “store and forward”

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<sup>16</sup> See Patricia C. Kuszler, *Telemedicine and Integrated Health Care Delivery: Compounding Malpractice Liability*, 25 AM. J.L. & MED. 297, 300 (1999) (discussing the development of telemedicine in the space industry).

<sup>17</sup> *Id.* at 301. The Papago program consisted of linking the reservation to a distant public health hospital by bringing “mobile health unit practitioners” onto the reservation. *Id.*

<sup>18</sup> Jeffrey C. Bauer, *Rural America and the Digital Transformation of Health Care: New Perspectives on the Future*, 23 J. LEGAL MED. 73, 76 (2002).

<sup>19</sup> Telepresence surgery combines robotic technology and telemedicine to allow a surgeon, located hundreds or thousands of miles away, to operate on a patient. *Id.* at 78. In telepresence surgery, a surgical technician makes small openings and inserts probes consisting of cameras and surgical tools, which allow the distance surgeon to conduct the surgery via remote control by viewing images on a high-resolution monitor. *Id.*

<sup>20</sup> An example of electronic patient records is the Patient Data Management System, which organizes and tracks information “such as the time of the consult [and] the patient and providers’ names” and can capture images and heart and lung sounds from a telemedicine consultation. Medical College of Georgia, *supra* note 7.

<sup>21</sup> Due to advances in digital and compression technology, vast amounts of information can be stored on small chips. See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 47. Smart Cards are an application of this technology in which a person’s entire medical history can be stored on a card the size of a credit card. *Id.*

technology.<sup>22</sup> The U.S. military has come to extensively use telemedicine<sup>23</sup> for purposes such as treating personnel in battle, on ships, and in airplanes.<sup>24</sup>

## II. TELEMEDICINE IN GEORGIA

### A. *The Medical College of Georgia Telemedicine Project*

Because there is no national telemedicine program, the development of telemedicine falls to the states.<sup>25</sup> The Medical College of Georgia (“MCG”) established one of the largest telemedicine systems in the United States, linking sixty remote locations to MCG.<sup>26</sup> The program began in November 1991, when MCG started a telemedicine pilot project by joining forces with Dodge County Hospital in Eastman, Georgia.<sup>27</sup> The program expanded to seven sites by the end of 1993.<sup>28</sup>

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<sup>22</sup> “Store and forward” technology allows medical practitioners to capture high-resolution color or grayscale images such as x-rays, video and sound clips, and other information and send them using standard communication channels to a distant health provider who can review the images instantly or at a later time. See Kristen R. Jakobsen, Note, *Space-Age Medicine, Stone-Age Government: How Medicare Reimbursement of Telemedicine Services Is Depriving the Elderly of Quality Medical Treatment*, 8 ELDER L.J. 151, 157 (2000). Eventually, the providers will be able to upload these images into the patient’s electronic medical record for remote viewing. Chari J. Young, Note, *Telemedicine: Patient Privacy Rights of Electronic Medical Records*, 66 UMKC L. REV. 921, 924 (1998).

<sup>23</sup> See *Telemedicine Technologies: Hearing Before the Subcomm. on Science, Technology, and Space of the Senate Comm. on Commerce, Science, and Transportation*, 106th Cong. 16–17 (1999) (statement of Ronald K. Poropatich, M.D., Member, Board of Directors, American Telemedicine Association).

<sup>24</sup> See generally *DOD Medical Programs, National Security Subcomm. of the House Appropriations Comm.*, 106th Cong. (1999) (statement of Lieutenant General Ronald R. Blanck, Surgeon General, U.S. Army). Telemedicine applications include a “reality helmet” allowing combat medics to talk with physicians after a soldier is wounded but before the soldier can be removed from the battlefield. See *Defense Health Programs: Statement on Health Care in the United States Army before the Senate Armed Services Personnel Comm.*, 106th Cong. (1999) (statement of Lieutenant General Ronald R. Blanck, Surgeon General, U.S. Army).

<sup>25</sup> For a description of the Georgia system, for example, see *Telemedicine: An Information Highway To Save Lives: Hearing Before the Subcomm. on Investigations and Oversight of the House Comm. on Science, Space, and Technology*, 103d Cong. 40 (1994) (statement of Dr. Jay H. Sanders, M.D.) (hereinafter *Telemedicine: An Information Highway To Save Lives*).

<sup>26</sup> See Huie, *supra* note 5, at 381. The Distance Learning and Telemedicine Network Governing Board—described more completely in the text accompanying *infra* note 31—awarded the MCG approximately \$10 million for telemedicine program operations from 1994 until June 2000. See Medical College of Georgia, *supra* note 7. In addition, MCG contributed a total of around nine million dollars of its own funds for program development and operations. *Id.*

<sup>27</sup> Medical College of Georgia, *supra* note 7.

<sup>28</sup> *Id.*

During MCG's expansion, Governor Zell Miller signed Senate Bill 144, The Distance Learning and Telemedicine Act of 1992,<sup>29</sup> with "the intention and purpose . . . that a state-wide distance learning and telemedicine network be developed whereby . . . delivery of medical care to all areas of the state will be improved."<sup>30</sup> The Act established a Distance Learning and Telemedicine Network Governing Board ("Governing Board") to create policies, review applications, and award funding.<sup>31</sup> As of April 2001, the Governing Board assigned management responsibilities for the Telemedicine Program to the Georgia Technology Authority.<sup>32</sup>

The most recent telemedicine initiative in Georgia involves state psychiatric hospitals and community mental health centers.<sup>33</sup> Dr. R. Kevin Grigsby, director of research for the MCG Telemedicine Center, stated that in Georgia, "more than half the 159 counties have no psychiatrist and only 19 counties have at least one child psychiatrist."<sup>34</sup> This initiative will be the "largest long-distance patient-examination system in the country."<sup>35</sup> In addition to hospitals and ambulatory care centers, clinics and correctional facilities will benefit from the project.<sup>36</sup>

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<sup>29</sup> GA. CODE ANN. §§ 50-5-190 *et seq.* (2002). The Act defined telemedicine as "an interactive telecommunications system that utilizes audio, video, and other appropriate elements and is compatible with other telemedicine networks and that is used for the purpose of enhancing the delivery of medical care to medical facilities throughout Georgia." *Id.* § 50-5-192(6).

<sup>30</sup> *Id.* § 50-5-191(b). The goals for the telemedicine program of Senate Bill 144 included: increasing access for socioeconomically or geographically remote patients, augmenting continuing medical education and support for rural-based providers, eliminating unnecessary patient travel, enhancing the quality and affordability of medical care, and efficiently using Georgia's medical resources by creating an integrated statewide network of primary, secondary, and tertiary care. Medical College of Georgia, *supra* note 7.

<sup>31</sup> GA. CODE ANN. § 50-5-196. The Governing Board, through the Georgia Board of Regents, assigned the duties of developing and managing the telemedicine program to the Telemedicine Center at MCG. *See* Medical College of Georgia, *supra* note 7.

<sup>32</sup> Medical College of Georgia, Center for Telehealth, Management of the GSTP No Longer Funded, at <http://www.mcg.edu/telehealth/MgmtofGSTP.htm> (Apr. 13, 2004). However, the Telemedicine Center at the MCG continues as part of the telemedicine network. For example, the Center has an ongoing contract with the United States Department of Energy to develop and implement a telemedicine program for the United States-Russia Nuclear Cities Initiative. *Id.*

<sup>33</sup> This telepsychiatry initiative began in 1995 and continues to grow. Medical College of Georgia, Center for Telehealth, Thriving Telepsychiatry Program Expands into Northeast Georgia, at <http://www.mcg.edu/telehealth/Psych2.htm> (Apr. 13, 2004).

<sup>34</sup> Toni Baker, Medical College of Georgia, Center for Telehealth, Psychiatric Care, at <http://www.mcg.edu/telehealth/Psych.htm> (Apr. 13, 2004). A \$1.5 million National Patterns of Academic Excellence grant from the University System of Georgia Board of Regents funds this initiative. *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.* Patient satisfaction surveys show that 92% of telepsychiatry patients thought the care was the same as if they had seen the psychiatrist in person. Toni Baker, Medical College of Georgia, Center for Telehealth, Telepsychiatry Clinic Meets Needs of Future Psychiatrists and Patients, at <http://www.mcg.edu/telehealth/Tel>

### B. *Telemedicine in Rural Georgia*

In the United States, rural areas have a shortage of doctors, and some patients must travel hundreds of miles to get to the nearest hospital.<sup>37</sup> According to the Georgia Rural Health Association, 118 of Georgia's 159 counties are rural,<sup>38</sup> of which at least ninety are designated as Health Professional Shortage Areas ("HPSAs"),<sup>39</sup> meaning that they are rural and urban areas with a shortage of health professionals. Specifically, the definition includes areas with a ratio of 3500 or more people per full-time equivalent primary care physician.<sup>40</sup> Almost 47 million Americans were living in designated HPSAs as of 1998.<sup>41</sup>

The federal government recognized the barriers rural patients face in accessing quality medical care and devoted funds to developing telemedicine programs in rural communities, from which Georgia benefited.<sup>42</sup> The Rural Electrification Administration made low interest loans to Georgia's telephone and telecommunications companies to set up communication links for telemedicine.<sup>43</sup> The 1990 Farm Bill authorized \$60 million to assist rural hospitals and schools set up fiber-optic link-ups.<sup>44</sup> Furthermore, the 1996 Telecommunications Act created a Universal Service program that subsidizes

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epsychResRot.htm (Apr. 13, 2004).

<sup>37</sup> See *Rural Health Care Issues: Hearing before the Subcomm. on Health of the House Comm. on Ways and Means*, 104th Cong. 27–28 (1996) (statement of Jeffrey Human, Director, Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services). For example, "on a per capita basis, there are almost twice as many primary care physicians practicing in urban areas as there are in rural areas." *Id.*

<sup>38</sup> Georgia Rural Health Association, About GRHA, at <http://gain.mercer.edu/grha/abgrha.html> (last updated Nov. 21, 2003).

<sup>39</sup> See Lists of Designated Primary Medical Care, Mental Health, and Dental Health Professional Shortage Areas, 67 Fed. Reg. 7739, 7757–58 (Feb. 20, 2002), available at <http://bhpr.hrsa.gov/shortage/fedreg/7739-7788.htm>.

<sup>40</sup> Katherine Huang, Note, *Graduate Medical Education: The Federal Government's Opportunity To Shape the Nation's Physician Workforce*, 16 YALE J. ON REG. 175, 180 (1999).

<sup>41</sup> *Id.* As of 1995, 62.7% of the nation's rural counties were designated as HPSAs. *Id.*

<sup>42</sup> It is important to note that although federal funding exists, federal telemedicine programs do not.

<sup>43</sup> See *Rural Healthcare: Testimony Before the Senate Agriculture, Nutrition, and Forestry Comm.*, 104th Cong. (1994) (testimony of Douglas E. Henley, M.D., Board Chair of the American Academy of Family Physicians). In addition, the National Telecommunications and Information Administration ("NTIA"), within the Department of Commerce, has \$26 million to distribute in the form of matching grants to states for telecommunications development, including telemedicine. *Id.*

<sup>44</sup> *Id.*

telecommunication transmission charges to rural areas, in part for the practice of telemedicine.<sup>45</sup>

Georgia also recognizes the obstacles faced by rural healthcare providers and rural hospitals. In 1999, the Georgia legislature passed a bill creating a one-time grant for some hospitals in rural areas.<sup>46</sup> Using this grant, MCG developed its system, which permits a local, referring physician to provide on-line, real-time consultation with a distant specialist.<sup>47</sup> Dr. Jay Sanders, the previous director of the telemedicine center at MCG, estimates that “85 percent of the patients who previously had to be transferred out of the rural community to a secondary or tertiary care center are now kept in that rural community” because of the program.<sup>48</sup>

Telemedicine initiatives in Georgia continue to improve healthcare delivery in rural areas. Recently, the Office for the Advancement of Telehealth awarded a three-year federal grant to Southeast Telehealth Partners network, which was established to use telemedicine to improve rural access to healthcare.<sup>49</sup> The grant serves an eleven county area in Georgia that has a shortage of healthcare professionals, especially specialists.<sup>50</sup> The region of 189,000 inhabitants has only a few radiologists, ophthalmologists, and ear, nose, and throat specialists; one cardiologist, dermatologist, and neurologist; and no pediatric psychiatrists.<sup>51</sup> Because of the grant, residents’ access to specialty care increased to include services provided via telemedicine, including child and adolescent psychiatry, tuberculosis care, colposcopy,<sup>52</sup> pediatric neurology, and pediatric pulmonology.<sup>53</sup>

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<sup>45</sup> See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 7; see also Jonathan Gardner, *Medicare To Pay Docs Who Use Telemedicine*, MODERN HEALTHCARE, Sept. 8, 1997, at 24 (discussing federal government subsidies for rural areas including reimbursements for consulting physicians and infrastructure funding).

<sup>46</sup> See Lori Johnston, *Hospital Bill OK'd by Ga. Senate; Lt. Gov. Taylor's Measure Would Aid Rural Counties*, CHATTANOOGA TIMES & FREE PRESS, Mar. 7, 1999, at B3.

<sup>47</sup> See Medical College of Georgia, *supra* note 7.

<sup>48</sup> *Telemedicine: An Information Highway To Save Lives*, *supra* note 25.

<sup>49</sup> Medical College of Georgia, Center for Telehealth, Grant to Enhance Telemedicine Service in Southeast Georgia, at <http://www.mcg.edu/telehealth/OAT.htm> (Apr. 13, 2004). The Rural Telemedicine Grant program, a national program administered by the Office for the Advancement of Telehealth, Health Resources and Service Administration, U.S. Department of Health and Human Services, awards the funds. *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> Colposcopy is an examination of the cervix for cancerous or precancerous lesions after a positive Pap smear. Toni Baker, Medical College of Georgia Center for Telehealth, Three GSTP Facilities Participate in Colposcopy Feasibility Study, at <http://www.mcg.edu/telehealth/Colposcopy.htm> (Apr. 13, 2004).

<sup>53</sup> Medical College of Georgia, *supra* note 49.

### C. *Telemedicine Within Georgia's Prison System*

Another area in which Georgia successfully utilizes telemedicine is the prison system. In 2003, Georgia prisoners received 1719 telemedicine consultations.<sup>54</sup> Currently, the prison system takes advantage of five telemedicine specialty clinics.<sup>55</sup> Within Georgia's telemedicine system, the prison hospital of Augusta Correctional and Medical Institute serves as a hub, linking five other prisons to the system.<sup>56</sup> The telemedicine linkages to the state prisons happen in two ways: one way is a network between MCG, a secondary hub,<sup>57</sup> and a remote site prison. The second is a mobile van,<sup>58</sup> linked to MCG, that travels to the prison facilities.<sup>59</sup>

## III. CURRENT BARRIERS TO TELEMEDICINE

### A. *Standard of Care for the Practice of Telemedicine*

Physicians are not liable for malpractice if they act within the appropriate standard of care. The standard of care applied in a typical malpractice action is that of an average physician, exercising the degree of care and skill that is ordinarily exercised by the profession under the same or similar conditions in comparable surrounding circumstances.<sup>60</sup> This is a national standard and the

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<sup>54</sup> WILLIAM P. KISSEL, GEORGIA DEPARTMENT OF CORRECTIONS HEALTH SERVICES OVERVIEW FOR FY2003 (2d ed. 2004).

<sup>55</sup> *Id.* These clinics include dermatology, gastrointestinal, general medicine, infectious disease, and podiatry. *Id.*

<sup>56</sup> 2 Tim Henderson, *Telemedicine: State Profiles*, at <http://www.ncsl.org/programs/health/forum/telemed2.htm> (last visited May 17, 2005).

<sup>57</sup> The secondary hub is usually a prison hospital. *Id.*

<sup>58</sup> The van can serve up to four prisons. *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> Johnson v. Myers, 165 S.E.2d 739, 742 (Ga. Ct. App. 1968).

majority rule.<sup>61</sup> Based on this standard of care, malpractice actions in Georgia can be brought either in tort or in contract.<sup>62</sup>

To claim medical malpractice a plaintiff must prove three elements: (1) a physician-patient relationship and its accompanying duty to provide treatment in accordance with the standard of care; (2) a breach of the established standard of care; and (3) that the breach of the standard of care is the proximate cause of plaintiff's injury.<sup>63</sup> These seemingly straightforward elements become difficult in the telemedicine context, where a physician's practice could cross into a state with a different standard of care. In such a situation, the question arises as to which state's standard will apply in the event of a malpractice claim.

These elements also become difficult when determining which state will have jurisdiction over a claim brought against a telemedicine practitioner. One of the ways to establish a physician-patient relationship, the first element of a malpractice claim, is a consultation.<sup>64</sup> However, a problem inherent in telemedicine is the ambiguity surrounding where a consultation takes place. For example, if a physician in Texas treats a patient living in Georgia and misdiagnosis occurs, the patient needs to know if the consultation was considered to be in Georgia or in Texas to bring a proper claim.

Various proposals have been suggested for determining jurisdiction in a telemedicine case. One involves a patient being "electronically transported" to the state or country in which the consulting physician is located.<sup>65</sup> However, if

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<sup>61</sup> RESTATEMENT (SECOND) OF TORTS § 299A (1965). The minority rule is the locality rule. Under this rule, if a party proves that the healthcare services and facilities in the locality in which the alleged malpractice occurred are more suitable than those implicated by a statewide standard of care, then the court will apply the local standard. See Charles M. Lott, *Legal Interfaces in Telemedicine Technology*, 161 MIL. MED. 280, 280 (1996). Georgia does not adhere to the locality rule. Thus, physicians must exercise the same degree of care whether they practice in a large city or a small town. See *Packer v. Gill*, 388 S.E.2d 338, 340 (Ga. Ct. App. 1989). However, the locality rule is applied to the actions of a hospital in furnishing equipment and facilities because care provided at smaller hospitals is frequently limited by resources and location. *Gusky v. Candler Gen. Hosp., Inc.*, 385 S.E.2d 698, 700 (Ga. Ct. App. 1989).

<sup>62</sup> *Wolfe v. Virusky*, 306 F. Supp. 519, 520 (S.D. Ga. 1969), *rev'd on other grounds*, 470 F.2d 831 (5th Cir. 1972). A contract claim, as opposed to a tort claim, would be for a breach of duty arising out of the contract, such as abandonment of the patient without giving reasonable notice or providing an incompetent physician as a substitute. See *Scott v. Simpson*, 167 S.E. 920, 921 (Ga. Ct. App. 1933).

<sup>63</sup> *Goggin v. Goldman*, 433 S.E.2d 85, 87 (Ga. Ct. App. 1993).

<sup>64</sup> See Phyllis F. Granade & Jay H. Sanders, *Implementing Telemedicine Nationwide: Analyzing the Legal Issues*, 63 DEF. COUNS. J. 67, 68 (1996).

<sup>65</sup> See Christopher J. Caryl, Note, *Malpractice and Other Legal Issues Preventing the Development of Telemedicine*, 12 J.L. & HEALTH 173, 187 (1998).

states followed this proposal, not only would patients not be protected by the laws and medical boards of their states, they would also be burdened by having to file suit in another state.<sup>66</sup> In response to this difficulty, many courts have held that the physician-patient relationship will exist and evolve whether the consultation involved meeting in person, over the telephone, or through optic imaging.<sup>67</sup> For example, in *Clanton v. Von Haam*,<sup>68</sup> the Georgia Court of Appeals found that when a physician, who previously treated a patient for an unrelated condition, chose to return that same patient's phone call about another condition and to listen to her symptoms, a physician-patient relationship was not created.<sup>69</sup> Because the patient herself interpreted the conversation as a refusal of medical services, the court held that a physician-patient relationship did not exist because such a relationship must be consensual.<sup>70</sup> However, the court stated that in this situation, other patients might assume that the treatment recommendation created a consensual relationship.<sup>71</sup> Thus, a court might conclude that a telemedical consultation forms a physician-patient relationship because, in the telemedical context, when a physician agrees to treat or consult a patient, the procedure must be set up in advance by a primary physician. This advance preparation indicates consent by both parties. In telemedicine, the decision to treat a patient is both purposeful and deliberate. However, the standard of care under which the physician practicing telemedicine will be held liable is still uncertain because some states have a lower standard of care than others.<sup>72</sup> Thus, figuring out the location of the telemedicine consultation will help determine the applicable standard of care.

Further, telemedicine may involve the use of the latest technologies to treat patients.<sup>73</sup> Until the latest techniques or state-of-the-art procedures gain acceptance in the medical community, doctors do not have to use them to

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<sup>66</sup> *Id.*

<sup>67</sup> See, e.g., *Dougherty v. Gifford*, 826 S.W.2d 668, 674 (Tex. App. 1992) (finding that doctor created physician-patient relationship by accepting pathology work, conducting the laboratory analysis, and preparing the pathology report). But see *Reynolds v. Decatur Mem'l Hosp.*, 660 N.E.2d 235, 239 (Ill. App. Ct. 1996) (finding that, when doctor consulted another doctor via telephone about treatment for a patient, the primary doctor served as a shield, thus creating no liability between the advising doctor and the patient).

<sup>68</sup> 340 S.E.2d 627 (Ga. Ct. App. 1986).

<sup>69</sup> *Id.* at 630.

<sup>70</sup> *Id.* at 630-31.

<sup>71</sup> *Id.* at 630.

<sup>72</sup> For example, whereas some states compare physicians to a standard of care nationwide, Alabama limits the standard of care comparison to physicians in the same geographic community who are engaged in the same type of practice. ALA. CODE § 6-5-484(a) (1993).

<sup>73</sup> See *supra* notes 9-12 and accompanying text.

satisfy the standard of care.<sup>74</sup> However, an integral part of the standard of care is the duty to remain current.<sup>75</sup> With the continued emphasis on a provider's duty to remain current with no guidance as to how providers satisfy this duty, the standard of care in Georgia is unclear.

Although multiple options exist for establishing a standard of care that includes modern technology tools, a national standard of care—one that considers the degree of care and skill ordinarily exercised by doctors under the same or similar conditions nationwide—is most appropriate in the telemedicine context. A national standard makes sense in light of the likelihood of nationwide telemedicine practice. Providing healthcare is the same regardless of the state, so states could easily apply a national standard of care in medical malpractice lawsuits.

In *Robbins v. Footer*,<sup>76</sup> the Court of Appeals for the D.C. Circuit held that a nationally certified specialist will be subject to a national standard of care based upon the ubiquitous nature of telecommunications.<sup>77</sup> As access to the Internet and medical databases becomes easier, the standard of care to which physicians will be held will likely increase. Even though no court has required a physician to use telemedical contacts or engage in a telemedical consultation, the ability to obtain these more easily will likely coincide with an increase in the physician's duty of care.

For Georgia legislators to advocate effectively for a national standard, the proposed standard must address three issues. First, it must be clear and self-explanatory, so that both patients and providers considering telemedicine consultation will understand potential provider liability. Second, a standard of care for telemedicine must address not only the physician's duty to patients, but also ancillary issues such as required communication between physicians, clarification of the roles of the consulting and treating doctors, and additional equipment. A national standard addressing these ancillary issues will act as a checklist for telemedicine practitioners, providing more information to the patient and reducing practice variation in the telemedical context.

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<sup>74</sup> See Angela Roddey Holder, *Failure To "Keep Up" as Negligence*, 224 JAMA 1461, 1462 (1973) (noting that a physician is not required to adopt highly experimental methods but should keep abreast of widely published developments); see also Donald E. Kacmar, *The Impact of Computerized Medical Literature Databases on Medical Malpractice Litigation: Time for Another Helling v. Carey Wake-Up Call?*, 58 OHIO ST. L.J. 617, 621 (1997).

<sup>75</sup> See Holder, *supra* note 74, at 1462.

<sup>76</sup> 553 F.2d 123 (D.C. Cir. 1977).

<sup>77</sup> *Id.* at 128–29.

Third, an effective nationwide standard must also address the procedure for determining which state will exercise jurisdiction over a medical malpractice action. States have varying approaches; some do not address their jurisdictional reach, while others define the jurisdictional reach of telemedicine practice by statute.<sup>78</sup> Telemedicine partially revives the strategy of venue shopping because some states do not have statutes that delineate their jurisdictional reach over telemedicine practitioners.<sup>79</sup> It diminishes a party's ability to rely upon the law of his jurisdiction, and "[t]he financial ramifications of venue shopping are potentially devastating to the physician and hold the potential to discourage interstate telemedicine practice."<sup>80</sup> Due process prohibits a state from exercising jurisdiction over a defendant unless the defendant has minimum contacts with the state.<sup>81</sup> States must prove a substantial connection "between the defendant and the forum State necessary for a finding of minimum contacts [that] must come about by an action of the defendant purposefully directed toward the forum State."<sup>82</sup>

Physicians practicing interstate telemedicine will likely be subject to the jurisdiction of those states in which they practice medicine. Further, once a telemedicine consultant treats a patient in a state other than where the physician is licensed, that physician has likely established purposeful minimum contacts within the state.<sup>83</sup> If a physician is sued by a patient in another state for malpractice as a result of a telemedicine consultation, then the physician's contacts within the state should provide the basis for the lawsuit. In those states that permit periodic telemedicine consultations, the nonresident physician might argue that since the state legislature found infrequent telemedicine consultations too insignificant to regulate, such irregular contacts with the state are insufficient to maintain jurisdiction over the physician.<sup>84</sup>

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<sup>78</sup> See 225 ILL. COMP. STAT. 60/49.5 (2002). Out-of-state physicians "providing a service . . . to a patient residing in Illinois through the practice of telemedicine submits himself or herself to the jurisdiction of the courts of this State." *Id.* at 60/49.5(e).

<sup>79</sup> JIM REID, A TELEMEDICINE PRIMER: UNDERSTANDING THE ISSUES 79–80 (1996).

<sup>80</sup> *Id.* at 80.

<sup>81</sup> *World-Wide Volkswagen Corp. v. Woodson*, 444 U.S. 286, 291 (1980); *Int'l Shoe Co. v. Washington*, 326 U.S. 310, 316 (1945).

<sup>82</sup> *Asahi Metal Indus. Co. v. Super. Ct. of Cal.*, 480 U.S. 102, 112 (1987); see *Burger King Corp. v. Rudzewicz*, 471 U.S. 462, 475–76 (1985).

<sup>83</sup> See *Int'l Shoe*, 326 U.S. at 316. The more contact a physician practicing telemedicine has with a patient in another state, such as an interactive examination, discussion, and medical recommendations, the more likely the physician has established minimum contacts with the patient's state.

<sup>84</sup> "Since 1993, at least ten states have passed legislation or regulations requiring out-of-state physicians to obtain licensure in that state before providing medical services via telemedicine. Clearly, the states are concerned about the growing ease with which providers are practicing across . . . state lines." Phyllis Forrester

Defining guidelines and the appropriate standard of care will make it easier for physicians wanting to practice telemedicine, and for patients seeking such treatment. By enacting a statute delineating the reach of the practice of telemedicine within its borders, Georgia would clarify liability for physicians practicing telemedicine while insuring that the best interests of the patient are met.

## B. *Telemedicine Licensure*

### 1. *Georgia's Approach to Licensure*

Occupational licensure has historically fallen within the province of the states and, therefore, Georgia has authority to enact licensure regulations to protect the health and safety of its citizens.<sup>85</sup> Thus, for a physician to practice telemedicine in Georgia, the physician must obtain licensure from the state. Georgia is one of several states with “full licensure” laws.<sup>86</sup> These laws require out of state telemedicine practitioners to be fully licensed in the state where their patients reside.<sup>87</sup>

Telemedicine practice may be interstate, and a physician must be licensed in each state in which he practices.<sup>88</sup> If a physician violates the statute within a state, he risks disciplinary proceedings,<sup>89</sup> which could include criminal penalties, Medicare debarment, and invalidation of malpractice insurance. In Georgia, any person practicing medicine within the state but without a Georgia license will be guilty of a felony and, if convicted, punished with “a fine of not less than \$500.00 nor more than \$1,000.00 or by imprisonment from two to five years, or both.”<sup>90</sup>

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Granade, *Medical Malpractice Issues Related to the Use of Telemedicine—An Analysis of the Ways in Which Telecommunications Affects the Principles of Medical Malpractice*, 73 N.D. L. REV. 65, 87 (1997) (citation omitted).

<sup>85</sup> See U.S. CONST. amend. X (“The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.”). In *Dean Milk Co. v. City of Madison*, the Supreme Court established the premise that a state can exercise “its unquestioned power to protect the health and safety of its people.” 340 U.S. 349, 354 (1951).

<sup>86</sup> Thirty-nine states, including Georgia, and the District of Columbia have full licensure laws. See Wendi Johnson et al., *Telemedicine: Diagnosing the Legal Issues*, in HEALTH LAW HANDBOOK § 3:12 (Alice G. Gosfield ed., 2001), available at WL HTHLHB § 3:12.

<sup>87</sup> See *id.* § 3:4.

<sup>88</sup> See Huie, *supra* note 5, at 403.

<sup>89</sup> See generally 70 C.J.S. *Physicians and Surgeons* § 42 (1987).

<sup>90</sup> GA. CODE ANN. §§ 43-34-26, 46 (2002).

In Georgia, a person “physically located” outside Georgia who “performs an act that is part of a patient care service located in this state . . . is engaged in the practice of medicine in this state.”<sup>91</sup> Patient care services include, but are not limited to, “initiation of imaging procedures or the preparation of pathological material for examination, and [acts] that would affect the diagnosis or treatment of the patient . . . .”<sup>92</sup>

Georgia does have four exceptions to its full licensure requirements.<sup>93</sup> First, a doctor of medicine or a doctor of osteopathy located outside Georgia who provides a consultation at the request of a Georgia-licensed physician and “[p]rovides such services on an occasional rather than on a regular or routine basis” is not subject to full licensing in the state.<sup>94</sup> Second, a physician or osteopath licensed in a foreign country or another state is exempt for emergency consultations. Third, the requirements do not apply to consultations without compensation. Fourth, Georgia does not require licensing in the state when an approved medical school or state medical society invites an out of state licensed physician or osteopath to the state to engage in professional education through lectures or clinics.<sup>95</sup>

State medical boards engage in endorsement when they grant licenses to health professionals in other states with equivalent standards.<sup>96</sup> Although Georgia, like the majority of states, allows endorsement as a source for interstate licensure and reciprocity, the state board of medical examiners imposes further requirements.<sup>97</sup> For example, under the board’s regulation, the other state’s standards must be equal to or higher than those in Georgia, and the other state must also give reciprocity to licensed physicians of Georgia.<sup>98</sup>

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<sup>91</sup> *Id.* § 43-34-31.1(a).

<sup>92</sup> *Id.*

<sup>93</sup> Most states allow both consultation exceptions and endorsements, but these vary from state to state and can extensively limit the consulting physician’s actions. See Jay H. Sanders & Rashid L. Bashshur, *Challenges to the Implementation of Telemedicine*, 1 *TELEMEDICINE J.* 115, 117 (1995). Some states permit only a specific number of consulting exceptions per year. For example, Alabama allows a physician consultation exception for only ten days per calendar year. ALA. CODE § 34-24-74 (2002). Because most states enacted consultation exceptions before the creation of telemedicine, they were not meant to apply to ongoing telemedicine links, which results in telemedicine providers being unable to regularly practice telemedicine. See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 21.

<sup>94</sup> GA. CODE ANN. § 43-34-31.1(b)(1)(B). Since primary medical care is rarely on an occasional basis, it would not qualify under this exception.

<sup>95</sup> *Id.* § 43-34-31.1(b)(1)(A).

<sup>96</sup> *E.g., id.* § 43-34-29.

<sup>97</sup> See *supra* notes 95–96 and accompanying text.

<sup>98</sup> See Jay H. Sanders, *Telemedicine: Capabilities, Growth Projections and Attending Issues Surrounding Its Use*, 6 *J. PHARMACY & L.* 3, 7 (1996).

Because most telemedicine practitioners are licensed in a state with less stringent standards, endorsements do little to ease Georgia's strict licensing requirements.<sup>99</sup> Therefore, Georgia's attempts to relax its full licensure requirements by allowing these exceptions are insufficient to maintain Georgia's status as a national leader in telemedicine.<sup>100</sup>

As a result of its stringent licensing requirements, some scholars argue that Georgia effectively discourages the interstate practice of telemedicine.<sup>101</sup> They believe that full licensing requirements impede the development of telemedicine because instead of developing their practices in response to healthcare needs, telemedicine practitioners may operate only in states where licensure requirements are less strict and must stop practicing in states that require full licensure.<sup>102</sup> If practitioners do this, Georgia might lose its current telemedicine practitioners to other states, which will impede the status of its current telemedicine network. Nevertheless, Georgia received support for its licensure system in 1994 when the American Medical Association adopted a policy that all states should require a full license for physicians practicing telemedicine within a state.<sup>103</sup> Proponents of full licensure statutes argue that they ensure uniformity of quality of care.<sup>104</sup> The stronger position, however, is that these restrictions counteract telemedicine's ability to "transcend geographical barriers . . . between states."<sup>105</sup>

## 2. *Proposals for Georgia To Change Its Licensure Approach*

Even though the majority of states, like Georgia, allow exceptions to their licensing requirements, licensing will continue to impede the development of telemedicine networks unless standards and laws are harmonized. Currently,

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<sup>99</sup> *Id.*

<sup>100</sup> For instance, in 2002, Texas, which does not require full licensure, had a total of 36,094 telemedicine consults while Georgia only had 867. See Telemedicine Information Exchange, Telemedicine Programs Database, Individual Program Listing, at <http://tie.telemed.org/programs/browseByLocation.asp?countryFilter=US&sortOrder=Location&newWindows=> (last visited Apr. 28, 2005).

<sup>101</sup> For example, Dr. Jay Sanders believes these exacting requirements do not protect the patient but instead protect the economy. See Sanders, *supra* note 98, at 9–10. He testified before Congress in 1994 that physicians operating nationally in a telemedicine network were not treating patients in the patients' state. In his opinion, licensure boards should consider that the patient is "electronically transported" to the physician's state. *Id.* at 10.

<sup>102</sup> See Alison M. Sulentic, *Crossing Borders: The Licensure of Interstate Telemedicine Practitioners*, 25 J. LEGIS. 1, 23 (1999).

<sup>103</sup> See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 23.

<sup>104</sup> See Sulentic, *supra* note 102, at 23 ("[F]ull licensure . . . least disturbs the state's current quality standards and its disciplinary system.").

<sup>105</sup> See Sanders, *supra* note 98, at 7.

only thirty states have licensure laws pertaining specifically to telemedicine, which increases the difficulties faced by physicians who want to practice across state lines.<sup>106</sup>

The remainder of this Comment examines three proposals for the Georgia legislature to consider regarding telemedicine practitioners. First, Georgia could change its law to give practitioners a limited license allowing them to practice telemedicine only within the state. Second, Georgia could work toward creating reciprocity agreements with other states. Third, Georgia could promote a national system of licensure, giving authority to a common national organization<sup>107</sup> to determine licensing standards. Each of these approaches is less stringent than Georgia's current licensing laws.

*a. Individual State Licensure*

*i. Registration*

A registration system allows a health professional, licensed in one state, to practice medicine part-time in other states without meeting the other states' licensure requirements.<sup>108</sup> However, the health professional consents to the legal authority and jurisdiction of the host state.<sup>109</sup> By consenting, the health professional is liable for any breach of professional conduct in any state where she registers.<sup>110</sup> For example, California passed laws permitting the creation of a registration program for telemedicine providers.<sup>111</sup> If Georgia implemented California's program, a telemedicine provider in another state would have to consult with the Georgia patient's primary caregiver and licensed Georgia physician before being allowed to consult with the patient.<sup>112</sup> Out of state telemedicine providers could not receive calls from patients with whom they

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<sup>106</sup> U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 21–24. These states include Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Carolina, North Dakota, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Utah, West Virginia, Washington, and Wyoming. *Id.* at app. 2. For example, all states in the Eleventh Circuit have different telemedicine licensure laws. Georgia requires full licensure. GA. CODE. ANN § 43-34-31.1 (2002). Alabama requires special licensure for out of state physicians. ALA. CODE §§ 34-24-502, 503, 507 (2002). The last state, Florida, has no licensure laws pertaining to telemedicine.

<sup>107</sup> Delegates from each state could comprise this common national organization.

<sup>108</sup> See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 22.

<sup>109</sup> *Id.*

<sup>110</sup> *Id.*

<sup>111</sup> *Id.* at 23; see CAL. BUS. & PROF. CODE § 2060 (West 2003).

<sup>112</sup> See CAL. BUS. & PROF. CODE § 2060.

consulted in Georgia, designate a place to meet these patients, or open an office in Georgia.<sup>113</sup> Thus, by adopting this proposal, Georgia would be promoting telemedicine through cooperation among states while protecting its citizens by limiting the amount of contact practitioners can have with them.

*ii. Limited Licensure*

With limited licensure, practitioners obtain a license in the state where they practice but can also acquire a license in other states to provide specific health services in certain situations.<sup>114</sup> The Federation of State Medical Boards (“FSMB”) proposed a plan that allows each state to create a “telemedicine-only” license, a variation of the limited licensure model, thus permitting each state to establish its own standards.<sup>115</sup> To receive a license limited to telemedicine practice, practitioners would have to satisfy the criteria established by each state. Variations of this type of license can be seen in states that offer a “special purpose license” for out of state telemedicine practitioners, which exempts practitioners from the licensure requirement for practice within a medical specialty.<sup>116</sup> A typical special licensure statute provides that telemedicine practices are included within the practice of medicine, with telemedicine being the medical specialty.<sup>117</sup>

If Georgia adopted a special purpose licensure statute, it could remove many of the problems obstructing telemedicine practice while still retaining some control. First, it would eliminate uncertainty for telemedicine providers as to which procedures require licensure. Second, a special purpose license would allow Georgia to continue establishing standards to practice medicine in the state—“entry-to-practice standards”—by permitting Georgia to specifically

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<sup>113</sup> *See id.*

<sup>114</sup> *See* U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 22.

<sup>115</sup> Federation of State Medical Boards of the United States, A Model Act to Regulate the Practice of Medicine Across State Lines (Apr. 1996), available at <http://www.fsmb.org/Policy%20Documents%20and%20White%20Papers/telemed.htm> [hereinafter FSMB Model Act]. States adopting variations of this model include Alabama, Tennessee, and Texas. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 23.

<sup>116</sup> *See, e.g.*, 22 TEX. ADMIN. CODE § 163.14 (West 2003) (allowing physicians to obtain a special purpose license if they are at least twenty-one years of age, actively licensed in another state without restriction, certified in a medical specialty, and pass a Texas Medical Jurisprudence Exam); *see also* ALA. CODE §§ 34-24-500–08 (2003).

<sup>117</sup> For example, the FSMB Model Act defines the “[t]he practice of medicine across state lines” to include “the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment” or an out-of-state physician rendering treatment to an in-state patient though “transmission of individual patient data by electronic or other means.” FSMB Model Act, *supra* note 115.

delineate which telemedicine procedures are included within the practice of medicine as well as the practitioner's scope of practice.<sup>118</sup> However, if Georgia sets high entry-to-practice standards, telemedicine practitioners may find the procedures to acquire a special purpose license to be as burdensome as obtaining full licensure. If Georgia does not specifically delineate which telemedicine procedures are included within the practice of medicine, the special purpose license would per se limit the scope of practice to the level determined by Georgia by prohibiting physicians from physically practicing law in the state.<sup>119</sup> Further, even if Georgia's practice standards were not extremely stringent, the state could still impose limitations on the scope of the practice of telemedicine.<sup>120</sup> Lastly, the special purpose licensure statute would contain penalties for noncompliance.<sup>121</sup>

*b. Mutual Recognition*

Mutual recognition falls within the category of cooperative efforts between Georgia and other states. The system involves interaction between a home state and a host state in order to coordinate and synchronize standards for licensure and professional conduct.<sup>122</sup> Under this scenario, the licensing authorities of Georgia would enter into an agreement with the practitioner's home state to accept the policies and licensing procedures of the practitioner's home state.<sup>123</sup> Thus, the out of state provider would not need to acquire additional license to practice in Georgia.<sup>124</sup>

An example of mutual recognition is the creation of an interstate compact, which could be formed either by states enacting reciprocal legislation or by states establishing an organization for regulatory oversight.<sup>125</sup> The National

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<sup>118</sup> In Texas, only board certified specialists can practice telemedicine. 22 TEX. ADMIN. CODE § 163.14.

<sup>119</sup> *E.g.*, *id.* § 163.14(c) (prohibiting physicians with only special purpose licenses from physically practicing law in Texas).

<sup>120</sup> *See supra* notes 116, 118–19 and accompanying text. By limiting the scope of practice, Georgia might also enhance the quality of telemedicine practitioners.

<sup>121</sup> *E.g.*, 22 TEX. ADMIN. CODE § 163.14(e).

<sup>122</sup> *See* U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 22.

<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

<sup>125</sup> *E.g.*, *Seattle Master Builders Ass'n v. Pac. N.W. Elec. Power & Conservation Planning Council*, 786 F.2d 1359, 1363 (9th Cir. 1986) (citing *N.E. Bancorp, Inc. v. Bd. of Governors of Fed. Reserve Sys.*, 472 U.S. 159, 175–76 (1985)). The Constitution generally only authorizes interstate compacts with Congressional consent, but the Supreme Court ruled that formal Congressional approval is not necessary for a compact that “does not impermissibly enhance state power at the expense of federal supremacy.” *U.S. Steel Corp. v. Multistate Tax Comm'n*, 434 U.S. 452, 472 (1978).

Council of State Boards of Nursing's development of a Nurse Licensure Compact ("Compact") exemplifies the use of an interstate compact to resolve licensure issues.<sup>126</sup> Under the Compact, nurses are allowed to practice telemedicine in the states adopting the Compact without obtaining an additional license due to the creation of a unified standard that both the home and host state recognize.<sup>127</sup> The Compact also addresses disciplinary activity. The home state enforces its disciplinary standards for actions taken by the nurse in the home state, and the host state enforces its disciplinary standards by regulating the nurse's behavior in providing services in the host state.<sup>128</sup> The Compact uses a centralized information system requiring each state to share information concerning disciplinary actions with other party states.<sup>129</sup> These measures help to maintain and ensure high-quality care across state lines.

If Georgia chose to adopt a similar compact for nurses or physicians practicing telemedicine, it would waive its entry-to-practice standards for practitioners of other party states, but would continue to impose those standards on nurses or practitioners who apply for their initial license in Georgia.<sup>130</sup> Thus, Georgia would maintain its autonomy in forming entry-to-practice regulations, disciplinary standards, and malpractice laws within state lines. Georgia would continue to influence the quality of care because the nurse or physician would be subject to the disciplinary requirements of both Georgia malpractice laws and licensure statutes.

The idea of an interstate compact also has weaknesses for two reasons. First, if states in the compact have lower licensing standards than Georgia, the quality of care received by the patients in Georgia could decrease.<sup>131</sup> Second,

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<sup>126</sup> See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 23.

<sup>127</sup> *Id.* The Compact states that when a home state issues a license to one of its residents to practice nursing, it "will be [r]ecognized by each party state as authorizing a multi-state licensure privilege to practice as a registered nurse in such party state." *Id.* at 24. The state of Utah was the first to adopt the Compact. See National Council of State Boards of Nursing ("NCSBN"), Frequently Asked Questions Regarding the National Council of State Boards of Nursing, Nurse Licensure Compact (NLC), at [http://www.ncsbn.org/nlc/mlpvncompact\\_mutual\\_recognition\\_faqs.asp](http://www.ncsbn.org/nlc/mlpvncompact_mutual_recognition_faqs.asp) (last updated Oct. 5, 2004). Eleven other states had followed as of 2001. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 23.

<sup>128</sup> NCSBN, *supra* note 127.

<sup>129</sup> *Id.* The home state must treat a host state's account of a nurse's reported conduct in the same way it would treat the conduct if it occurred in the home state. NCSBN, Nurse Licensure Compact, Art. V(d) (Nov. 6, 1998), at [http://www.ncsbn.org/nlc/mlpvncompact\\_mutual\\_recognition\\_nurse.asp](http://www.ncsbn.org/nlc/mlpvncompact_mutual_recognition_nurse.asp).

<sup>130</sup> The NCSBN has compared its Compact to the cooperation among states concerning drivers' licenses. NCSBN, *supra* note 127. With drivers' licenses, a driver licensed in one state can drive in other states without obtaining a new license as long as he/she follows local laws for driving motor vehicles. See *id.*

<sup>131</sup> One solution to this problem would be for an interstate compact to require party states to adopt uniform standards for entry to practice or for the scope of practice.

an interstate compact could be invalidated as an “unconstitutional delegation of legislative authority” because absolute reciprocity would “allow other states’ legislatures the unqualified right to determine the qualifications for the practice of nursing in this state by nonresidents.”<sup>132</sup> Notwithstanding these weaknesses, an interstate compact has potential as a method for Georgia to license telemedicine practitioners.

*c. National Licensure*

National licensure has the potential to simplify the licensing process and the practice of telemedicine through its use of a universal standard.<sup>133</sup> Physicians could take a standardized test covering both medical knowledge and technical proficiency to receive a national telemedicine license.<sup>134</sup> The Telemedicine Task Force of the Center for Telemedicine Law<sup>135</sup> favors a uniform interstate licensure system,<sup>136</sup> which could be administered at the state or national level.<sup>137</sup>

If administered nationally, the federal government would create standards and preempt state licensure laws. One problem with a national standard is the legal authority of the states, which traditionally have the power to regulate the health and safety of their citizens.<sup>138</sup> However, because of its substantial effect on interstate commerce, Congress arguably has the authority to regulate this type of activity.<sup>139</sup> Another problem is that state revenue loss could also occur if administered at the national level. If federally established standards

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<sup>132</sup> See Attorney General of Kansas, Att’y Gen. Op. No. 99-3 (1999), at <http://www.nursingworld.org/gov/a/state/attgen99/Kansas.htm>.

<sup>133</sup> U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 22.

<sup>134</sup> See Derek F. Meek, Comment, *Telemedicine: How an Apple (or Another Computer) May Bring Your Doctor Closer*, 29 CUMB. L. REV. 173, 185 (1999). The examination for a national license could consist of parts of various state exams containing general medical knowledge with an additional focus on telemedicine technology. See *id.*

<sup>135</sup> The Center for Telemedicine Law is a nonprofit organization that addresses legal and regulatory issues relating to the development of telemedicine. See generally Center for Telemedicine Law, Home Page, at <http://wwwctl.org> (last visited Apr. 28, 2005).

<sup>136</sup> See *Telemedicine: State Licensing Laws Uncoordinated*, AM. POL. NETWORK, Feb. 14, 1997, LEXIS, All News File.

<sup>137</sup> U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 22. At the national level, federal agencies would administer the system by issuing a license, valid throughout the United States. *Id.* Even if federal agencies administer the system, the Task Force supports giving the states disciplinary authority because of the higher accountability of the states to their citizens. See *Telemedicine: State Licensing Laws Uncoordinated*, *supra* note 136.

<sup>138</sup> See *supra* note 85 and accompanying text.

<sup>139</sup> United States v. Lopez, 514 U.S. 549, 559 (1995).

governed licensure, they would preempt state licensure laws such that licensing fees might be paid to the federal government instead of the states.<sup>140</sup>

Administering this system on the state level could minimize both of these problems.<sup>141</sup> If administered by the states, the federal government would not establish the standards but would allow the states to do so collectively.<sup>142</sup> Congress could organize this collective forum, and state representatives would have to agree on the same standards and criteria for the practice of telemedicine. However, considering the wide range of licensing requirements currently existing among the states, this could be a convoluted process.

The military successfully uses a federally administered national licensing system. A physician in the military can practice anywhere in the United States, provided that he is a member of the armed forces and holds a valid license issued by a state, the District of Columbia, or a commonwealth, territory, or possession of the United States.<sup>143</sup> These regulations apply not only to physicians but also to dentists, clinical psychologists, nurses, and any other person designated by the Secretary of Defense as being engaged in direct patient care.<sup>144</sup> This system allows healthcare providers to extend their practices geographically beyond their original licenses for the primary purpose of providing care to military personnel.<sup>145</sup>

### 3. *Georgia's Best Solution: Dual Licensure*

As evident from the foregoing sections, licensure presents the greatest barrier to telemedicine, especially in states like Georgia that require practitioners to go through the full licensure process before practicing telemedicine within their borders. The previously discussed proposals give Georgia multiple options to lessen its stringent full licensure requirements while still retaining some control over telemedicine practitioners treating residents within the state.

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<sup>140</sup> See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 22.

<sup>141</sup> *Id.*

<sup>142</sup> If administered by the states collectively, the system would be similar to the mutual recognition model embodied in the Nurse Licensure Compact.

<sup>143</sup> 10 U.S.C. § 1094(d), (e)(1) (2000).

<sup>144</sup> *Id.* § 1094(e)(2).

<sup>145</sup> See 32 C.F.R. § 728.1 (2004) (describing the mission of Navy medical facilities).

The best solution to Georgia's strict licensing standards is a "dual licensing system."<sup>146</sup> This system would be national, but Georgia and other states would retain control over doctor-patient interactions occurring within their borders.<sup>147</sup> To obtain a dual license, physicians would have to comply with two requirements. First, physicians must have a state license before applying for a national telemedicine license.<sup>148</sup> Second, physicians must still have a state license for face-to-face treatment; thus, physicians could only practice telemedicine with the national license.<sup>149</sup> This compromise would allow telemedicine practitioners to practice telemedicine nationally while ensuring that Georgia, along with other states, would be able to control quality of care within its borders through disciplinary and malpractice proceedings for violations occurring in the state.

Georgia would benefit from a national license by increasing its residents' access to healthcare.<sup>150</sup> A national license has the potential to expand the use of telemedicine in Georgia as it is likely to be less strict than the current full licensure requirements, thus attracting more healthcare providers to serve its rural population. A drawback of a federally administered national licensing system is that Georgia would no longer be able to establish standards for its telemedicine practitioners.<sup>151</sup> However, the dual-license would allow Georgia to continue to set some quality standards. Thus, Georgia would maintain the role and ability to discipline its own healthcare providers for violating professional standards.

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<sup>146</sup> See Brian Darer, Note, *Telemedicine: A State-Based Answer to Health Care in America*, 3 VA. J.L. & TECH. 4, ¶ 19 (1998), at [http://www.vjolt.net/vol3/issue/vol3\\_art4.pdf](http://www.vjolt.net/vol3/issue/vol3_art4.pdf).

<sup>147</sup> *Id.*

<sup>148</sup> *Id.*

<sup>149</sup> *Id.*

<sup>150</sup> "Development of telemedical services is then a reasonable approach to closing service gaps" between rural communities and urban areas. Max E. Stachura, *The Georgia State-Wide Telemedicine Network: Some Lessons Learned*, 7 J. TELEMEDICINE & TELE CARE 62 (2001).

<sup>151</sup> See *Gentry v. Volkswagen of Am., Inc.*, 521 S.E.2d 13, 16 (Ga. Ct. App. 1999) ("Congress—through federal laws and regulations—may effectively preempt state law in three ways: (1) express preemption; (2) field preemption (regulating the field so extensively that Congress clearly intends the subject area to be controlled only by federal law); and (3) implied (or conflict) preemption.").

### C. *Reimbursement in Georgia*

The third barrier to telemedicine development is the lack of public and private insurer reimbursement.<sup>152</sup> Currently, federal grants and special contracts provide most of the financial support for programs.<sup>153</sup> Lack of funding makes it more difficult to deliver healthcare services using telemedicine.<sup>154</sup> For telemedicine to thrive within Georgia, the state must push its current providers, including Medicare, Medicaid, and private insurers, to reimburse physicians for telemedicine consultations and examination. In addition to encouraging public and private insurer reimbursement, Georgia should undertake reimbursement measures itself.

#### 1. *Medicare and Medicaid*

The first medical center in the country to receive Medicare reimbursement for telemedicine consultations was MCG's Telemedicine Center.<sup>155</sup> As early as 1993, Medicare began reimbursing providers for "physician to physician" telemedicine consultations between MCG and Dodge County Hospital in Eastman, Georgia.<sup>156</sup> In May 1995, Medicare began reimbursing all Georgia State Telemedicine Program sites for telemedicine consultations from one physician to another.<sup>157</sup> In October 1996, Medicare announced that it would begin a limited project to study telemedicine.<sup>158</sup> The project provided payments for telemedicine consultations based on Medicare's waiver authority. The payments were limited to four states, one of which was Georgia.<sup>159</sup>

Despite these initial steps made by Medicare, Congress chose to step in when it passed the Balanced Budget Act of 1997 ("BBA") requiring the

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<sup>152</sup> See Dena S. Puskin, *Telemedicine: Follow the Money*, ONLINE J. OF ISSUES IN NURSING, Sept. 30, 2001, at [http://nursingworld.org/ojin/topic16/tpc16\\_1.htm](http://nursingworld.org/ojin/topic16/tpc16_1.htm) (attributing the slow growth of telemedicine use to severely limited reimbursement programs).

<sup>153</sup> For example, Georgia's telemedicine network receives its funding from a federal grant from the Office for the Advancement of Telehealth and a contract with CyberCare, Inc. Telemedicine Information Exchange, Telemedicine Programs Database, Individual Program Listing, at <http://tie.telemed.org/programs/showprogram.asp?item=2661> (last visited Apr. 28, 2005).

<sup>154</sup> See Puskin, *supra* note 152.

<sup>155</sup> See Bradham et al., *supra* note 15, at 164. The MCG's Telemedicine Center also received Medicaid reimbursement. *Id.*

<sup>156</sup> Medical College of Georgia, Center for Telehealth, Georgia Statewide Telemedicine Program—Reimbursement History, at <http://www.mcg.edu/telehealth/ReimbursementHist.htm> (Apr. 13, 2004).

<sup>157</sup> *Id.*

<sup>158</sup> Joint Working Group on Telemedicine, Telemedicine Report to Congress, Payment for Telemedicine Services, at <http://www.ntia.doc.gov/reports/telemed/payment.htm> (Jan. 31, 1997).

<sup>159</sup> *Id.*

Centers for Medicare and Medicaid Services (“CMS”)<sup>160</sup> to pay for telemedicine consultation services beginning January 1, 1999.<sup>161</sup> Although this was a step in the right direction, many telemedicine providers found the BBA provisions too narrow.<sup>162</sup> First, the only eligible patients for reimbursement under the BBA were those residing in HPSAs.<sup>163</sup> This limitation did not take into account patients in rural areas who have sufficient primary care resources, such as a nurse or general practitioner, but who lack specialty resources such as cardiologists or psychologists.<sup>164</sup> Second, under the BBA, Medicare reimbursement rates for physician teleconsultations were set at 75% of face-to-face reimbursement rates.<sup>165</sup> Third, for the physician to be paid, the eligible presenter<sup>166</sup> had to be either the referring physician or an employee of the referring physician.<sup>167</sup> However, registered nurses, licensed practical nurses, or health technicians are the only staff in most rural clinics, all of whom were ineligible presenters.<sup>168</sup> To address these limitations, the House and Senate presented nine different bills with telehealth provisions in the 106th Session.<sup>169</sup>

In December 2000, Congress passed the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (“BIPA”),<sup>170</sup> removing many of BBA’s limitations. BBA stated that the originating site must be the office of a practitioner or physician, a critical access hospital, rural health

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<sup>160</sup> Before June 2001, the CMS was known as the Health Care Financing Administration (“HCFA”). See Centers for Medicare and Medicaid Services, Acronym List, at <http://www.cms.hhs.gov/acronyms/results.asp?Acronym=hcfa> (last modified Sept. 16, 2004).

<sup>161</sup> Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4207, 111 Stat. 251, 377 (1997) (codified as amended in 42 U.S.C. § 1395b-1 (2000)).

<sup>162</sup> See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 17. After two years of telemedicine reimbursement, Medicare only reimbursed a total of \$20,000 for 301 teleconsultation claims. *Id.*

<sup>163</sup> *Id.*

<sup>164</sup> *Id.*

<sup>165</sup> Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1999, 63 Fed. Reg. 58,814, 58,886 (Nov. 2, 1998). The remaining 25% is paid to the referring practitioner. *Id.*

<sup>166</sup> An “eligible presenter” is a specific healthcare professional permitted to engage in telemedicine consultations as designated by the BBA Act. See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 3.

<sup>167</sup> Revisions to Payment Policies and Adjustments to the Relative Value Units, 63 Fed. Reg. at 58,886.

<sup>168</sup> See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 17–19. The University of Missouri, conducting a survey of twenty telehealth networks representing 4761 telehealth encounters, found that only 7% of the referring practitioners acted as patient presenters in consultations, suggesting that of all the telehealth encounters reported, less than 7% would meet HCFA’s eligible presenter criteria. *Id.*

<sup>169</sup> *Id.*

<sup>170</sup> Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, § 1(a)(6), 114 Stat. 2763 (2000) (incorporating by reference H.R. 5661, 106th Cong. (2000)).

clinic, federally qualified health center, or a hospital; BIPA expanded the acceptable locations of telemedicine reimbursement to include all counties not included in a metropolitan area and any entity participating in a federal telemedicine demonstration project.<sup>171</sup> BIPA also eliminated the requirement that the prescribing physician be present during the teleconsultation, and provides full reimbursement for a physician consultation.<sup>172</sup>

However, Medicare still does not reimburse for online consultations between a physician and patient using email.<sup>173</sup> Further, Medicare does not reimburse for evaluative services for Medicare beneficiaries; it only reimburses for interactive services.<sup>174</sup> Part of CMS's reason for limiting payment to face-to-face consultations is "the potential for 'unreasonable use of telemedicine' and 'destabilizing' rural providers and hospitals."<sup>175</sup> For example, abuse could occur in the nursing home environment where a physician consults a group of patients at the same time but collects an individual fee for each patient.<sup>176</sup> In addition, telemedicine could provide competition to current rural providers which, in turn, might reduce their client base, causing them to leave the underserved area.<sup>177</sup>

Medicaid programs generally look to services covered by Medicare to determine what treatments they will include as part of their payments.<sup>178</sup> Currently, Medicaid covers telemedicine expenses in Georgia and eighteen other states.<sup>179</sup> Under Medicaid, the majority of states, including Georgia, reimburse for interactive video conferencing during physician consultations.<sup>180</sup> In Georgia, Medicaid reimburses at both the providing and receiving sites on a

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<sup>171</sup> See 42 C.F.R. § 410.78(b)(4) (2004) (stating that the telemedicine consultation must be in "either a rural [HPSA] . . . or in a county that is not included in a Metropolitan Statistical Area as defined in section 1886(d)(2)(D)" of the Public Health Service Act, 42 U.S.C. § 254e(a)(1)(A) (2000)). A telemedicine demonstration is a federally funded program. See *id.*

<sup>172</sup> See *id.* § 410.78(c) (stating that the prescribing physician need not be present for payment unless the physician's presence is medically necessary as determined by a practitioner at the distant site).

<sup>173</sup> See Robert A. Gerberry, *Legal Ramifications of the Formation of Digital Hospitals*, HEALTH LAW., June 2002, at 27, 31.

<sup>174</sup> *Id.* Thus, Medicare will not reimburse for "store and forward" technologies. *Id.*; see *supra* note 22.

<sup>175</sup> See Sanders, *supra* note 98, at 14.

<sup>176</sup> *Id.*

<sup>177</sup> *Id.*

<sup>178</sup> See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 19.

<sup>179</sup> See *id.*

<sup>180</sup> See Centers for Medicare and Medicaid Services, Medicaid and Telemedicine, at <http://www.cms.hhs.gov/states/telemed.asp> (last modified Sept. 16, 2004) [hereinafter CMS, Medicaid and Telemedicine]; Centers for Medicare and Medicaid Services, States Where Medicaid Reimbursement of Services Utilizing Telemedicine Is Available, at <http://www.cms.hhs.gov/states/telelist.asp> (last modified Sept. 16, 2004).

fee-for-service basis equal to reimbursement for services provided in conventional, face-to-face consultations.<sup>181</sup>

Medicaid may also cover nonphysician practitioners depending on their scope of practice under state law.<sup>182</sup> In addition, some states cover mental health services and medical consultations.<sup>183</sup> A few states even have laws prohibiting insurers from discriminating between traditional medical services and telemedicine services.<sup>184</sup>

## 2. Other Payment Coverage

Some private insurers also provide limited telemedicine coverage in certain states. For example, as of January 2001, 150 private providers were reimbursing most telemedicine services in Georgia.<sup>185</sup> Specifically, Blue Cross/Blue Shield of Georgia began reimbursing telemedicine consultations in 1993.<sup>186</sup> Currently, Blue Cross/Blue Shield of Kansas is the only private insurance carrier providing payment for all telemedicine services.<sup>187</sup> Other carriers pay for telemedicine services in limited situations.<sup>188</sup> In addition, some managed care plans are using telemedicine applications to keep their market share in rural areas.<sup>189</sup>

Starting as early as 1994, a few states required private insurers who solicit customers in their states to offer some type of coverage for telemedicine services. For instance, Louisiana passed a law preventing insurance carriers from differentiating between telemedicine and other methods of healthcare delivery.<sup>190</sup> In 1996, California enacted State Bill 1665, requiring all private

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<sup>181</sup> CMS, Medicaid and Telemedicine, *supra* note 180.

<sup>182</sup> *Id.* For example, the practice of radiology via telemedicine is covered by all fifty states. *Id.*

<sup>183</sup> See Bill Siwicki, *Progress on the Payment Issue*, HEALTH DATA MGMT., Aug. 19, 1997, at 46, 46 (noting, for example, that Kansas Medicaid reimburses physicians for mental healthcare services provided via telemedicine).

<sup>184</sup> U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 19. These states include California, Texas, and Louisiana. *Id.*

<sup>185</sup> See Medical College of Georgia, Center for Telehealth, Reimbursement, at <http://www.mcg.edu/telehealth/Reimbursement2.htm> (Apr. 13, 2004).

<sup>186</sup> Medical College of Georgia, *supra* note 156.

<sup>187</sup> See Jakobsen, *supra* note 22, at 167.

<sup>188</sup> See *id.* Blue Cross/Blue Shield of Montana and West Virginia have such plans. *Id.* One report states that 8% of telemedicine providers have negotiated payments from private insurers. See generally Joint Working Group on Telemedicine, *supra* note 159 (discussing payment issues).

<sup>189</sup> See Joint Working Group on Telemedicine, *supra* note 159. Allina Health Systems is an example of a of successful managed care model utilizing telemedicine applications. *Id.*

<sup>190</sup> See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 19.

insurers to establish a reimbursement policy for telemedicine services.<sup>191</sup> Texas also passed a law preventing private payers from not paying for telemedicine consultations when consultations could have been conducted face-to-face.<sup>192</sup>

### 3. *Reimbursement Proposal*

In the early 1990s, Georgia established the precedent for reimbursing telemedicine services. However, other states are presently more progressive with reimbursement. Georgia should follow the example of Louisiana and enact legislation to prevent private insurance providers from discriminating against telemedicine as a method for distributing healthcare services.<sup>193</sup>

Georgia should require all insurance providers to provide the same type of reimbursement as that for covered services in conventional, face-to-face interactions. Private insurers report that telemedicine visits can cost as little as one-third of the price of on-site care.<sup>194</sup> Also, telemedicine saves an estimated \$36 billion per year in healthcare costs.<sup>195</sup> By adopting legislation for equivalent reimbursement for telemedicine services, Georgia could reduce the healthcare costs to both the state and the patient.<sup>196</sup> Further, studies indicate that demand for medical procedures dramatically increases when insurance

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<sup>191</sup> S.B. 1665, Reg. Sess. (Cal. 1996), available at [http://www.leginfo.ca.gov/pub/95-96/bill/sen/sb\\_1651-1700/sb\\_1665\\_bill\\_960925\\_chaptered.html](http://www.leginfo.ca.gov/pub/95-96/bill/sen/sb_1651-1700/sb_1665_bill_960925_chaptered.html).

<sup>192</sup> See TEXAS STATEWIDE HEALTH COORDINATING COUNCIL, THE STATE OF TELEMEDICINE AND TELEHEALTH IN TEXAS 104 (2002), available at <http://www.texasshcc.org/tmreport.pdf> (referring to Texas Senate Bill 789).

<sup>193</sup> See Roger Fillion, *Sharing the Health: Technology Expands Long-Distance Care*, DENVER POST, Apr. 5, 1999, at C-01 (noting that the lack of insurance reimbursement for telemedicine programs has been a key stumbling block). Texas and Oklahoma have also enacted nondiscrimination statutes prohibiting insurance companies from refusing to pay for medical care because it is delivered through telemedicine. See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 19. As an international leader in telemedicine, Norway introduced a fee schedule with full reimbursement by the national healthcare service back in 1996. Jakobsen, *supra* note 22, at 170. Because of the program's success, telemedicine as a healthcare delivery system has become part of Norway's welfare system and is reimbursable despite income or geography. *Id.*

<sup>194</sup> See Siwicki, *supra* note 183, at 46 (reporting on Blue Cross/Blue Shield of Kansas).

<sup>195</sup> See Ann K. Schooley, Note, *Allowing FDA Regulation of Communications Software Used in Telemedicine: A Potentially Fatal Misdiagnosis?*, 50 FED. COMM. L.J. 731, 733 (1998).

<sup>196</sup> Telemedicine reduces costs for both the state and the individual by lowering transportation costs (i.e., between a patient's home and a distant specialist), reducing duplication of tests at another facility, decreasing medical record errors, increasing efficiency of administrative tasks, and providing healthcare more efficiently. *Id.*

providers cover the type of service used to deliver the procedure.<sup>197</sup> If providers cover telemedicine services, more Georgians will opt to use telemedicine for healthcare delivery. Thus, Georgia should change its current reimbursement policies by requiring insurance providers to reimburse not only for interactive services but also for evaluative services.

If more patients choose to receive healthcare via telemedicine, Georgia will benefit because providers, through reimbursement of services, will help bear the costs of operating Georgia's telemedicine network. Also, since Georgia recently expanded its telemedicine network to include treatment at psychiatric hospitals and community mental health centers,<sup>198</sup> it should also require its providers to cover mental health services and medical consultations using telemedicine as the method of providing these services.

Another way the state could facilitate reimbursement is to provide funding for physicians in underserved areas. One of the main barriers to implementing telemedicine is that hospitals in rural communities lack the capabilities and initial capital to start a telemedicine program.<sup>199</sup> However, once a telemedicine program is established, hospitals can expand their services at nominal cost. More importantly, rural hospitals are more likely to remain economically viable if more patients can be treated at their facilities.

One of Georgia's other major goals in developing a telemedicine program is education.<sup>200</sup> Georgia should provide funds or tax incentives for facilities using telemedicine for continuing medical education. Some scholars argue that when federal or state entitlement programs cover a service, private providers are more likely to do the same.<sup>201</sup> By initiating the reimbursement of telemedicine services, such as education, Georgia will likely be more effective in asking other providers to reimburse for telemedicine services.

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<sup>197</sup> See Daniel McCarthy, *The Virtual Health Economy: Telemedicine and the Supply of Primary Care Physicians in Rural America*, 21 AM. J.L. & MED. 111, 118 (1995).

<sup>198</sup> See *supra* notes 33–36 and accompanying text.

<sup>199</sup> These costs range from roughly \$134,000 to \$288,000 per institution in initial set-up costs and from \$19,000 to \$80,000 annual transmission and maintenance fees. See Joint Working Group on Telemedicine, *Telemedicine Report to Congress, Evaluation* (Jan. 31, 1997), at <http://www.ntia.doc.gov/reports/telemed/evaluate.htm>.

<sup>200</sup> See *supra* notes 29–32 and accompanying text.

<sup>201</sup> See generally John B. Reiss, *Commentary on Payment and Reimbursement Issues Affecting the Marketing of Drugs, Medical Devices, and Biologics, with Emphasis on the Anti-Kickback Statute and Stark II*, 52 FOOD & DRUG L.J. 99 (1997).

Georgia's success in continuing to operate its telemedicine network will be easier if a steady flow of reliable funds provides the resources. At the very least, Georgia must mandate that its own state entitlement programs provide some level of coverage for telemedicine services. However, the best action for the Georgia legislature to take is to enact a nondiscrimination insurance provision, which precludes the exclusion of coverage when patients and their physicians choose telemedicine for the delivery of healthcare. If patients receive the same reimbursement from a telemedicine consultation as a regular face-to-face consultation in a doctor's office, they will be more likely to request and approve telemedicine services, which will contribute to the continued expansion and development of Georgia's telemedicine system.

#### *D. Privacy and Confidentiality*

##### *1. Introduction*

Telemedicine, through the digitalizing of medical records, has the ability to improve patient care, lessen human errors, and decrease the cost of the delivery of healthcare. Physicians estimate that when they are treating a patient, approximately 40% of critical information is unavailable.<sup>202</sup> Centralizing patient information will allow a healthcare provider to review a patient's history, see a listing of the patient's medications and allergies, and view digital images of the tests performed.<sup>203</sup> However, with the digitalizing of medical records also comes potential exposure to and liability for hackers illegally receiving and sharing confidential healthcare information electronically. By addressing these potentialities in the articulation of telemedicine-specific standards, in addition to adhering to existing federal protections, Georgia can prevent privacy concerns from acting as a barrier to the advancement of telemedicine.

##### *2. Federal Protections*

Congress enacted the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to expand patient privacy to meet the current state of

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<sup>202</sup> Gerberry, *supra* note 173, at 28.

<sup>203</sup> Despite these advantages, electronic medical records are implemented in only 5% of hospitals. Daniel J. Roy, *Privacy, Compensation Barriers Obstruct Bush's Goal of Electronic Medical Records*, 13 HEALTH L. REP. 139, 139 (2004).

healthcare technology.<sup>204</sup> HIPAA requires that the National Committee on Vital and Health Statistics recommend national standards for electronically maintaining patient medical and health information.<sup>205</sup> All “individually identifiable health information,” including information in written, electronic, or spoken form between healthcare providers, is protected.<sup>206</sup> As a result, the use and disclosure of personally identifiable health information is protected “regardless of the form the information is kept in, the methods of transmission, the time sequence of its creation and use, or the way it is communicated.”<sup>207</sup> Because this information is protected, it cannot be generally disseminated without the patient’s consent and, with a few exceptions, it can be used for health purposes only.<sup>208</sup> HIPAA seeks to facilitate this electronic dissemination of patient information while maintaining privacy by implementing standards that create patient identifiers.<sup>209</sup> By May 2007, healthcare providers will use a national provider identifier for all healthcare claims.<sup>210</sup>

To balance these privacy protections, the Department of Health and Human Services (“HHS”) is establishing rules allowing existing disclosures without individual consent for certain national priority activities and activities facilitating the operation of the healthcare system.<sup>211</sup> HIPAA requires covered

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<sup>204</sup> See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections of 45 U.S.C.).

<sup>205</sup> See National Committee on Vital and Health Statistics (“NCVHS”), NCVHS Reports and Recommendations, available at <http://www.ncvhs.hhs.gov/reptrecs.htm> (listing NCVHS’s latest reports and recommendations for health privacy and confidentiality) (last visited May 17, 2005).

<sup>206</sup> See 42 U.S.C. § 1320d(6) (2000) (defining “individually identifiable health information”); *id.* § 1320d-6 (discussing the offense and penalties for wrong disclosure of individually identifiable health information). Some of the national standards that have been established include standards for the privacy of individual health information, standards for administration that exchange health information electronically, and secure electronic signatures to access medical records. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 33.

<sup>207</sup> See 42 U.S.C. § 1320d(6); *id.* § 1320d-6.

<sup>208</sup> See 45 C.F.R. § 164.508 (2004); *id.* § 164.512. For example, the exceptions allow a covered entity, in response to law enforcement’s request, to disclose health information about an individual who is suspected to be the perpetrator of a crime or about inmates currently in lawful custody. *Id.* § 164.512(b)(6).

<sup>209</sup> See Roy, *supra* note 203, at 140–41.

<sup>210</sup> *Id.* at 141.

<sup>211</sup> U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 96. Some of these national priority activities for which entities may disclose information include those relating to national security and defense, judicial and administrative proceedings, emergency circumstances, and limited law enforcement activities. *Id.* at 96–97. Activities facilitating the operation of the healthcare system include oversight of the healthcare system, ensuring healthcare quality, healthcare research, and facility patient directories. *Id.*

entities<sup>212</sup> to employ and maintain “appropriate administrative, technical, and physical safeguards . . . to protect against any reasonably anticipated . . . threats or hazards to the security or integrity of the information . . . .”<sup>213</sup> Any covered entity not in compliance with HIPAA regulations is subject to penalty.<sup>214</sup>

Each state has its own laws governing patient privacy.<sup>215</sup> When enacting HIPAA, Congress set a national floor of privacy standards, but it also safeguarded existing state confidentiality laws—that is, HIPAA did not preempt these individual state mandates.<sup>216</sup> However, HHS proposed that the federal requirements should preempt state law when the state privacy protections are weaker.<sup>217</sup> This proposal adds the further protection of medical information in states with little protection, while giving a physician advance notice of minimum privacy standards.

### 3. *Georgia’s Protections*

Although Georgia must comply with the HIPAA minimum privacy requirements, Georgia should explicitly articulate standards for the transmission of information during a telemedicine session. Currently, all those who practice medicine in Georgia via telemedicine<sup>218</sup> must comply with Georgia state law regarding the maintenance and confidentiality of patient

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<sup>212</sup> Covered entities include healthcare providers, health plans, and healthcare clearinghouses that conduct financial and administrative electronic transactions. *Id.* at 94.

<sup>213</sup> 42 U.S.C. § 1320d-2(d)(2) (2000). The deadline for compliance by covered entities was October 16, 2003. *See Roy, supra* note 203, at 140. Because of the difficulty in implementing HIPAA’s transaction rules, the Centers for Medicare & Medicaid Services stated that it would allow legacy formats, which are the electronic formats currently in use, to be used indefinitely for Medicare. Press Release, Centers for Medicare and Medicaid Services, Medicare Announces Plan to Accept HIPAA Non-Compliant Electronic Transactions After October 16 Compliance Deadline, *at* <http://www.cms.gov/media/press/release.asp?Counter=870> (Sept. 23, 2003).

<sup>214</sup> 42 U.S.C. § 1320d-5 (indicating the penalties for failing to comply with the standards and requirements). For unintentional violations, the Secretary can impose a fine of up to \$100 per violation not exceeding \$25,000 per year. If a person discloses or obtains protected health information wrongfully, the Secretary can impose a fine of up to \$50,000 and/or imprisonment of up to one year. *Id.* § 1320d-6(b). The most severe penalty, for a violation with the “intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm,” is a fine up to \$250,000 and imprisonment for up to ten years. *Id.*

<sup>215</sup> U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 14, at 34.

<sup>216</sup> *See id.*

<sup>217</sup> *See id.*

<sup>218</sup> Georgia defines telemedicine as “the use of any means, including electronic, radiographic, or other means of telecommunication, through which medical information or data is transmitted.” GA. CODE ANN. § 43-34-31.1(a) (2002).

records and patient information.<sup>219</sup> Physicians and healthcare providers must comply with Georgia's privacy and confidentiality laws, regardless of where they are located and regardless of how Georgia's hospitals maintain patients' records.<sup>220</sup> Because confidentiality provisions specifically addressing patients' rights when using telemedicine do not exist in Georgia, one can infer that existing confidentiality protections, such as those against transmission of information and access to medical records, apply to telemedicine. Although Georgia's privacy statutes reasonably protect individuals, Georgia needs to address specifically the confidentiality of patient records and patient information within the telemedicine context.

Practically all medical information presented and acquired during a telemedicine consultation is in electronic form, which heightens privacy concerns. Within the telemedicine context, the patient's records and medical history will be shared with the consulting physician as well as with two sets of staff and possibly with technicians supporting the system. Further, many confidentiality issues arise with telemedicine, such as easy accessibility to electronic patient information, conveyance of video images, presence of additional persons, possible loss of control over the route of medical information, and reliability of electronic record keeping. Georgia law should address these concerns by requiring telemedicine practitioners to comply with telemedicine-specific privacy statutes.<sup>221</sup> Without specific privacy protections, telemedicine will not be seen as a viable treatment alternative.

Some communication and disclosure of information is necessary in the telemedicine context. Thus, Georgia should allow telemedicine providers to communicate information related to treatment decisions with other healthcare providers or participants in an organized healthcare arrangement without violating the law. However, to protect the patient, this new legislation should also require practitioners to obtain patient consent before disseminating any patient-identifiable images or other patient-identifiable information from the telemedicine consultation to any persons or entities not present at the consultation.<sup>222</sup> Additionally, as part of a patient's informed consent, Georgia should require telemedicine practitioners to notify the patient of anyone who

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<sup>219</sup> *Id.* § 43-34-31.1(d).

<sup>220</sup> *Id.*

<sup>221</sup> For example, California has specifically addressed health care providers utilizing only electronic record systems. CAL. HEALTH & SAFETY CODE § 123149 (West 2005).

<sup>222</sup> *See* CAL. CIV. CODE § 56.20 (West 2005).

will have access to the patient's health information<sup>223</sup> and of the privacy risks inherent in electronic transfers.

Although these suggestions are by no means exclusive, they are some of the issues that the Georgia legislature must address. If Georgia does not specifically confront privacy in telemedicine, patients' privacy will be endangered.

#### CONCLUSION

Telemedicine has the ability to transform the healthcare industry by addressing critical problems, such as cost, quality, and access to medical care. Its continuing success in Georgia depends on whether the state is ready to answer this call to action and remove the current barriers facing telemedicine's advancement. By having the largest telemedicine network in the nation,<sup>224</sup> Georgia is in a unique position to shape the healthcare industry. To do so, Georgia must change its current policies concerning telemedicine.

Four barriers obstruct the development of telemedicine in Georgia: standard of care, licensure, reimbursement, and privacy. The Georgia legislature and medical profession must address each of these to facilitate the development of telemedicine in the state. First, Georgia should modify its standard of care for telemedicine practitioners by supporting a national standard of care including not only the physician's duty to his patient but also Georgia's jurisdictional reach over telemedicine practitioners. Second, Georgia should adopt a dual licensing system, which would allow telemedicine practitioners to practice in Georgia with a national telemedicine license, making it easier for them to practice telemedicine within the state, while also allowing Georgia to retain its full licensure requirements for face-to-face examinations. Third, Georgia should commence state initiatives requiring its public insurers to reimburse for all telemedicine services and mandate that its own state entitlement programs provide coverage for telemedicine services. Fourth, to ensure confidentiality of electronic medical records and telemedicine consultations, Georgia should go beyond the HIPAA standards and specifically address confidentiality requirements within the telemedicine framework.

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<sup>223</sup> For example, those who operate the telemedicine equipment will have access to private medical information by virtue of their presence at the consultation.

<sup>224</sup> See *supra* note 7 and accompanying text.

Until Georgia answers this call to action, the provision of healthcare via telemedicine will be in jeopardy. Georgia needs to maintain an effective and long-lasting network amid current barriers. As a pioneer in telemedicine's early period, Georgia's reformulation of its telemedicine policies will allow the state to continue to cyberblaze healthcare trails in the future.

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