Teleradiology Guidelines Set Standards for Practice

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ACR’s teleradiology guide tackles privacy, credentialing, and other elements to help establish best practices for the burgeoning field.

Ezequiel Silva III, MD, knew he had a delicate balancing act ahead of him.

Charged with leading the American College of Radiology taskforce for creating the first teleradiology best practices guidelines, Silva set out to acknowledge the positive of the burgeoning field while reigning in any activities that had previously gone unchecked.

He and his fellow authors were quick to acknowledge the rapid expansion of teleradiology that has lead to critics and fans alike. And they were deliberate in tackling the unique challenges facing the field.

“We’re not condemning or commending it either,” Silva, a radiologist at the South Texas Radiology Group in San Antonio, Texas, and the University of Texas Health Science Center radiology department, said of teleradiology. “We tried very purposefully to go about it objectively. We looked at experts, regulatory issues, technology, standards and quality. This was not in reaction to concerns we had. It was not a response to complaints. It was an objective exercise to create the standards.”

As they formed the guidelines over nearly a year and half, Silva and his colleagues took on a wide range of subjects including licensing, credentialing, billing, ghost reading, peer review and workplace environment.

Even as the authors refrained from denigrating teleradiology, they did make one clear judgment on the practice: On-site radiology and radiologists are preferred.

“Although the task force understands and appreciates the benefits teleradiology brings to the profession and the communities we serve, we also believe the traditional practice model of having on-site, local radiology groups may better serve the overall interests of most communities,” the authors concluded. They recommended the ACR focus member education on how to take on leadership roles and other noninterpretive services within their hospitals and communities.

What emerged, however, is a document that Joe Moock, CEO of the national teleradiology company StatRad, called a must-read tool for the industry.

“It discusses a lot of the things that are very relevant,” he said. “I think it is a great tool for us to use and it is showing that ACR is saying this is important. My hope is that all telerad companies follow this guide and provide expert care.”

To begin, the task force formed a broad definition of the subject that includes not only the large teleradiology companies that take on work throughout the country, but also the common practice of local groups helping to cover smaller regional and community hospitals. Any time a diagnostic image is transmitted for interpretation beyond the immediate vicinity of where the image was taken, that’s considered teleradiology, Silva said.

“Even within the same hospital system,” he noted.
Most importantly, Silva said, was their decision to keep the patient first. Teleradiologists, after all, should operate at the same high standards of any other radiologist, he said. “The needs of the patient supersede everything else,” he emphasized.

In many instances, Silva and his co-authors took from established ACR guidelines, and framed them to fit the realities of teleradiology. Ghost reading is unacceptable. Teleradiologists should participate in formal peer review. And no matter where a reading room exists, it should make use of the advances in ergonomics that have been proven in studies to aid accurate diagnosis. Additionally, privacy laws must be adhered to and any radiologists reading from anywhere in the country must hold the proper licensures and hospital credentialing for the place where the patient is being treated.

“It’s important to emphasis how important those requirements are in licensing, credentialing and privacy,” Silva said. “Teleradiologists must have a private and secure space so that it is physically located in secure place and the interface is secure as well for transmitting images, including meeting encryption and technical standards.”

While the licensing and medical staff requirements are “nothing new” and nearly universally followed, Moock said he was pleased to see the emphasis put on peer review, quality improvement and communication with other onsite medical staff.

Even as some of the teleradiology best practices are already wildly established, the authors also took on topics where there a precedent isn’t as strong. They clearly tackled CMS billing regulations, including emphasizing the need to adhere to the government’s anti-markup ruling that forbids a billing facility from “marking up” the claim for professional services beyond what the providing physician would otherwise receive.

The authors also treaded carefully, but deliberately, as they laid out guidance for establishing contracts for teleradiology. Agreements should delineate areas that the authors themselves emphasized in the white paper, including defining credentialing requirements and quality assurance. “There wasn’t a whole lot out there describing contracting relationships for using teleradiology entity,” Silva said. “This wasn’t intended to be legal advice but it was meant as a list of issues that should stimulate the right conversations.”

Calling the paper “a living document” Silva said he hopes that it leads to many conversations on the evolving field but above all that the best interests of patients remain at the forefront.

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