PROFESSIONAL LIABILITY ASSOCIATION, INC.
RISK RETENTION GROUP, INC.

TELEMEDICINE SUPPLEMENTAL QUESTIONNAIRE

Name (please print) _____ **Policy Number (if current CARE insured)** _____

Directions: Please answer all questions fully and completely. If a question does not apply to your practice, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. Please ensure that you sign and date the questionnaire on page 4.

SECTION ONE: GENERAL

Telemedicine is defined as "the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a licensed health care practitioner and patient constitutes telemedicine."

1. What percentage of our medical practice is or will be dedicated to telemedicine services? _____%
2. Do you have a written agreement or contact to provide telemedicine services? _____ Yes ____No
   If yes, please submit copies of your telemedicine agreements and contracts.
3. Please identify the type(s) of telemedicine services that you provide (check all that apply):
   ___ Review and render an opinion regarding images, slides, etc. that are sent from a distant or remote site.
   ___ Perform surgery and/or procedures on patients who are at a distant or remote site.
   ___ Render services in or on behalf of an electronic/virtual intensive care unit.
   ___ Other (please provide a detailed description in the Remarks section on page 4).
4. Are your procedures for ensuring privacy and security of patient information in compliance with the Health Insurance Portability and Accountability Act (HIPAA)? _____ Yes _____ No
   If no, please explain:

5. Do any of the following situations or actions occur in a state other than the one in which you maintain your primary practice location, or in a country other than the United States?

   Patients reside or present for diagnosis or treatment ____Yes ___No
   Specimens are taken or images are made? ____Yes ___ No
   Slides, images, etc. are sent from? ____Yes ___ No
   Slides, images, etc. are reviewed or interpreted? ____Yes ___ No

   If you answered yes to any one of the above, please complete the following table:

State or Country	Estimated # Occurring Weekly	State or Country	Estimated # Occurring Weekly

Do you maintain an active medical license in each state or country? ____Yes ___ No

If no, please explain and identify the states and/or countries in which you do not maintain an active medical license:

SECTION TWO: INTERPRETATION OF IMAGES, SLIDES, ETC.

NOTE: Please complete this section only if you indicated for question 3 in Section One that you review and render an opinion regarding images, slides, etc. that are sent from a distant or remote site.

1. Please complete the following table regarding all facilities from which the images, slides, etc., will be sent:

Name and location (city and state) of facility	**Type of facility (for example, hospital of imaging center)**	**Are you credentialed at the facility?**	**Type(s) of items reviewed (for example, mammography)**
		___Yes ___No	
		___Yes ___No	
		___Yes ___No	
		___Yes ___No	

2. If any facility in question 1 is NOT a hospital, are the persons performing the x-rays, etc. at the sending site licensed and/or certified by the state in which they are located? ___Yes ___No
   If no, please explain:

3. If any facility identified in question 1 is NOT a hospital, please provide proof of the facility's professional liability insurance

4. How do you transit the results of your reviews (for example, via email, the internet, a postal service) and to whom?

5. How do you confirm receipt of your reports?

6. When viewing images generated at distant or remote sites, do you digitize images or do you have access to the original absorption data to enable you to manipulate or reformat the images? ___Yes ___No
   If no, please explain:

7. Do you interpret images, slides, etc. generated at distant or remote sites in emergency situations?____Yes ___No
   If yes, does another physician perform an over read within 24 hours of your reading? ___Yes ___No
   If no, please explain:

SECTION THREE: OFF-HOURS COVERAGE ("NIGHTHAWK" SERVICES)

1. Do you provide nighthawk services on behalf of other physicians or medical groups? ___Yes ___No

   If yes, please complete the following:

   a. Please provide the name of each physician and/or medical group for whom you provide nighthawk services and the state or country of their practice location(s).

   b. Please provide proof of professional liability insurance for each physician and/or group.

   c. Does each physician and/or medical group for whom you are providing nighthawk services over read the studies that you have performed on its behalf within 24 hours of your reading?____Yes ___No

   If no, please explain:

   d. Who provides the official report to the ordering physician?_____

SECTION FOUR: TELESURGERY

NOTE: Please complete this section ONLY if you indicated for question 3 in Section One that you perform surgery and/or procedures on patients who are located at a distant or remote site.

1. How many telesurgery procedures do you anticipate performing in the next 12 months? _____

2. Please provide the following items:
   a. Proof of your hospital privileges for telesurgery
   b. Proof of your training on the surgical device(s) (e.g. certificates of course completion)
   c. A copy of your consent form
3. Please provide the following on a copy of your letterhead:
   a. The procedures(s) to be performed via telesurgery
   b. The name of each surgical device to be used and an indication as to whether each device has received FDA approval for the specific procedure(s) to be performed.
   c. A description of the proctoring procedure used during your training, including the credentials of the proctoring physician.
   d. The name and location of each facility at which you will be located when you perform the procedure and a description of each facility's experience in using the relevant surgical device.
   e. The name and location of each facility at which the patients will be located when the procedure is performed and a description of each facility's experience in using the relevant surgical device.

SECTION FIVE: ELECTRONIC/VIRTUAL ICU (eICU)

NOTE: Please complete this section ONLY if you indicated for question 3 in Section One that you render services in or on behalf of an electronic/virtual intensive care site.

1. Please complete the following regarding each eICU on behalf of which you render services:

Name and location (city and state) of eICU	Names and addresses of ICUs monitored by eICU	Type of professional relationship with eICU
		__ Employee __ Independent Contractor __ Other (please specify): _____
		__ Employee __ Independent Contractor __ Other (please specify): _____
		__ Employee __ Independent Contractor __ Other (please specify): _____
		__ Employee __ Independent Contractor __ Other (please specify): _____

   a. If the eICU monitors more than one ICU, are you personally responsible for monitoring more than one ICU at a time? ____Yes ___No
   If yes, what is the maximum number of ICUs that you will monitor at any one time? _____

   b. Are you credentialed at each facility monitored by the eICU? ___Yes ___No

   If no, please explain:

   c. Does each eICU identified above have an emergency backup power source. ____Yes ___No

   If no, please explain:

2. If each contract that you provided (as requested in Section One) does not specify your responsibilities and duties, please provide a detailed description of those responsibilities and duties on a copy of your letterhead.

REMARKS

Beneath "Question Number," please indicate the question number and, if applicable, the letter (for example, 2 or 3b)

Page Number Section Number Question Number Remarks

_____

_____

_____

_____

_____

Please provide any additional information to further describe your telemedicine practice that has not been otherwise addressed in this questionnaire:

REPRESENTATIONS AND WARRANTIES

Note: "Warrant" in the following statement is not applicable to Alaska, Arizona or New Mexico health care providers. By statute, Alaska, Arizona or New Mexico health care providers are only required to represent the truth of their statements and information.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify CARE Risk Retention Group, Inc. immediately if my practice changes in any way and of any changes in the information in this questionnaire

_____ _____

Signature Date

_____

Print Name