REPORT OF THE BOARD OF DIRECTORS

Subject: **Report of the FSMB Workgroup on Telemedicine:** ***The Appropriate Use of Telemedicine Technologies in the Practice of Medicine***

Referred to: **Reference Committee**

During its 2021 Annual Business Meeting, the Federation of State Medical Boards (FSMB) House of Delegates adopted a recommendation that called for the FSMB to establish a workgroup to update the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (HoD 2014)*, taking into account the lessons learned during the COVID-19 pandemic.

Accordingly, the FSMB Workgroup on Telemedicine – established by FSMB Chair Kenneth B. Simons, MD and chaired by Shawn P. Parker, JD, MPH – was charged to:

- Evaluate the impact of license waivers and modifications on the practice of telemedicine across state lines;
- Evaluate the easing of geographic, site specific and modality restrictions on the practice of telemedicine and the impact on patient access and care;
- Review current state and federal legislative, policy and regulatory trends, including, but not limited to, definitions, modalities, continuity of care, and consultations;
- Evaluate the appropriate use of telemedicine during a public health emergency vs. nonemergent/nonurgent times;
- Develop a report and recommendations revising and expanding the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*, based upon recent experiences, utilization, and outcomes related to intra- and interstate telemedicine practice.

Over the course of the year, the workgroup met four times, both virtually and in-person, and took into account lessons learned from the PHE and conducted a comprehensive review of extant state and federal statutes and regulations, telemedicine technologies currently in use and proposed/recommended standards of care, and identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards. In-depth discussions were had regarding the 2014 *Model Policy*, including sections that needed to be updated to reflect current best practices and standards of care, as well as topics that were not covered in the *Model Policy*, but should be included in the revised document.

A draft report was distributed to state medical boards and external partner organizations with a nexus to telemedicine during a 45-day comment period held from January 6 - February 16, 2022. The workgroup met via videoconference to discuss feedback received and provided input for its incorporation into a new draft.

The report includes the following updates and revisions to the 2014 *Model Policy:*

- Emphasizes that telemedicine is only one component of the practice of medicine

- Reorganizes the 2014 *Model Policy* into a format that better reflects the process of delivering healthcare.
- Defines new terms, and updates existing terms, to reflect current best practices and standards.
- Details instances where certain exceptions may permit the practice of medicine across state lines without the need for licensure in the jurisdictions where the patient is located.
- Emphasizes that a practitioner who uses telemedicine must meet the same standard of care and professional ethics as a practitioner using a traditional in-person encounter with a patient. The failure to follow the appropriate standard of care or professional ethics while using telemedicine may subject the practitioner to discipline by the medical board.
- Recognizes that when utilized and deployed effectively as a seamlessly integrated part of healthcare delivery, telemedicine can improve access and reduce inequities in the delivery of healthcare. To be effective, certain barriers must be eliminated or reduced, such as literacy gaps, access to broadband internet, and coverage and payment of telemedicine services.

The Appropriate Use of Telemedicine Technologies in the Practice of Medicine¸ which will supersede the 2014 *Model Policy*, was distributed to the FSMB Board of Directors' Executive Committee electronically and approved at its meeting on March 21, 2022.

ITEM FOR ACTION:

The Board of Directors recommends that:

The House of Delegates ADOPT *The Appropriate Use of Telemedicine Technologies in the Practice of Medicine,* superseding *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (2014).*

THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Report of the FSMB Workgroup on Telemedicine
Submitted to the FSMB House of Delegates, April 2022

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INTRODUCTION

In April 2014, the Federation of State Medical Boards (FSMB) adopted the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practices of Medicine,* superseding the *Model Guidelines for the Appropriate Use of the Internet in Medical Practice (2002).* At the time of its adoption, the *Model Policy (2014)* addressed current regulatory challenges associated with the provisions of telemedicine. Since then, the utilization of telemedicine has dramatically increased, resulting in not only advancements in telemedicine technologies, but also identification of newer or more pressing challenges to effective telemedicine utilization.

There are numerous factors contributing to the continual increase of telemedicine being used as a component of the practice of medicine. The greatest of these catalysts by far has been the global COVID-19 pandemic and resulting national public health emergency (PHE). Prior to the declaration of a PHE by the United States, telemedicine visits accounted for a small percentage of total care visits, but within the first six months of the PHE, total telemedicine visits increased by more than 2,000 percent. Certain specialties, such as psychiatry, endocrinology and neurology, saw greater increases in telemedicine utilization than others. The PHE increased familiarity with telemedicine for patients and providers alike and signals greater use in the future.[1,2] Telemedicine allows continued relationships between patients and providers after both office-based and telemedicine visits. Patients and physicians alike also now expect telemedicine to continue to be a component of healthcare delivery.

The rapid expansion of telemedicine has at the same time led to concerns regarding fraud and abuse, patient safety and access inequity. While the PHE led to rapid expansion of telemedicine, counties in the United States with lower median income, less broadband availability, and less pre-PHE telemedicine use continue to utilize telemedicine at a far lesser rate than other counties.[3] Additional patient groups have also experienced inequity of telemedicine access, including older adults, those with limited English proficiency, and people from certain racial and ethnic minority groups. In 2019, despite the ubiquitous appearance of smartphone and related devices availability, 25 million Americans lacked internet access, while 14 million people did not have equipment capable of sharing or playing video images, such as a laptop, pc computer, smartphone, tablet or

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[1] Cortex C, Mansour O, Qato DM, Stafford R, Alexander C. Changes in Short-term, Long-term, and Preventative Care Delivery in US Office-Based and Telemedicine Visits During the COVID-19 Pandemic. *Jama Health Forum.* 2021;2(7):e211529. Doi:10.1001/jamahealthforum.2021.1529

[2] Mehrotra A, Chernew M, Linetsky D, Hatch H, Cutler D, Schneider E. The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases. The Commonwealth Fund. 22 Feb 2021.

[3] Patel S, Rose S, Barnett M, Huskamp H, Uscher-Pines L, Mehrotra A. Community Factors Associated with Telemedicine Use During the COVID-19 Pandemic. *Jama Netw Open.* 2021;4(5):e2110330. Doi:10.1001/jamanetopen.2021.10330.

other device. Specifically, 18 percent of adults aged 65 or older did not have internet access at home, 13 percent of people living in non-metropolitan areas lacked internet access, and seven percent living in metropolitan areas lacked internet access.[4] These marginalized and minoritized communities may be left behind despite advancements in telemedicine and improved access to care, unless such inequities are addressed.

Telemedicine is one component of the delivery of healthcare, and it can vary in quality, appropriateness and usefulness. It is important that as telemedicine continues to be utilized, regulatory agencies balance expanding regulatory opportunities for the adoption of telemedicine technologies with ensuring public health and safety. To address the challenges and evolving use of telemedicine, as well as apply lessons learned from the COVID-19 pandemic, Kenneth B. Simons, MD, the Chair of the Federation of State Medical Boards (FSMB), appointed the Workgroup on Telemedicine in May of 2021 to revise and expand the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (2014)* to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards"), health care providers and patients. The Workgroup was charged with evaluating the impact of license waivers and modifications on the practice of medicine across state lines; evaluating the easing of geographic, site-specific and modality restrictions on the practice of telemedicine and the impact on patient access and care; reviewing current state and federal legislative, policy and regulatory trends; and evaluating the appropriate use of telemedicine during a public health emergency versus nonemergent/nonurgent times.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine, while raising awareness for licensees and patients alike as to the appropriate standards of care in the delivery of medical services via telemedicine technologies. The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation. It is the intent of the workgroup to offer a model policy for use by state medical boards and lawmakers to expand regulatory opportunities and enable wider, appropriate adoption of telemedicine technologies for delivering care while ensuring the public's health and safety.

In developing the guidelines that follow, the workgroup took into account lessons learned from the PHE and conducted a comprehensive review of extant state and federal statutes and regulations, telemedicine technologies currently in use and proposed/recommended standards of care, and identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

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[4] Amin K, Rae M, Ramirez G, Cox C. How Might Internet Connectivity Affect Health Care Access? Peterson-KFF Health System Tracker. December 14, 2020. https://www.healthsystemtracker.org/chart-collection/how-might-internet-connectivity-affect-health-care-access/#item-start

SECTION 1. Model Guidelines for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine in the United States and offer opportunities for improving the delivery and accessibility of health care, particularly through telemedicine. Telemedicine continues to be best defined as the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location, with or without an intervening healthcare provider. State medical boards, in fulfilling their statutory duty to protect the public, often face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient consistent with the same standard of care; and 4) limiting the inappropriate prescribing and dispensing of certain medications.

The [Name of Board] recognizes the potential benefits of the use of telemedicine technologies to deliver medical care. When utilized appropriately, telemedicine technologies can enhance connection between patients and physicians, and reduce inequities in the delivery of care. Telemedicine technology can facilitate patient examinations and permit diagnosis, if acceptable under the standard of care. Telemedicine technologies also enable remote patient monitoring and permit physicians to obtain medical histories, give medical advice and counseling, and prescribe medication and other treatments.

These guidelines do not alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method of enabling physician-to-patient communications. Telemedicine is one component of the practice of medicine. A physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history taking of the patient consistent with established, evidence-based standards of care for the particular patient presentation. When the standard of care that is ordinarily applied to an in-person encounter cannot be met by virtual means, the use of telemedicine technologies is not appropriate.

The Board has developed these guidelines to educate licensees and the public as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible and safe practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

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- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

Physicians are encouraged to comply with nationally recognized health standards and codes of ethics. There should be consistent ethical and professional standards applied to all aspects of a physician's practice. A physician's professional discretion as to the diagnoses, scope of care, or treatments should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e., a prescription or referral) or the utilization of telemedicine technologies.

Section Two. Licensure

A physician must be licensed, or appropriately authorized, by the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time that telemedicine technologies are used. Physicians who diagnose, treat, or prescribe using online service sites are engaging in the practice medicine and must possess appropriate licensure in all jurisdictions where their patients receive care.[5]

There are a few instances, however, where certain exceptions may permit the practice of medicine across state lines without the need for licensure in the jurisdictions where the patient is located. These exceptions to licensure are only permissible for established medical problems or ongoing workups and care plans, or in cases of prospective patient screening for complex referrals. Should medical care be sought by the patient for a different medical diagnosis or condition, the physician must refer the patient to a physician licensed in the state where the patient is located or obtain a license to practice medicine in the state where the patient is located. Specifically, these exceptions are:

Consultations and Screenings

Physician-to-Physician Consultations

The physician-to-physician consultation exception permits a consulting physician licensed in another state in which they are located to use telemedicine or other means to consult with a licensed practitioner who remains responsible for diagnosing and treating the patient in the state where the patient is located.

[5] To avoid confusion about when a physician does or does not require a license to practice across state lines, states are encouraged to consider various means of license portability. States may promote license portability by joining national compacts, such as the Interstate Medical Licensure Compact, as one mechanism to help physicians achieve necessary multi-state licensure to legally provide care to patients in other states.

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Prospective Patient Screening for Complex Referrals

Physicians providing specialty assessments or consultations, such as at Centers for Excellence, are not required to obtain a license in the state where the patient is located in order to screen a patient for acceptance of a referral. The out-of-state physician may then provide care via telemedicine utilizing the physician-to-physician consultation exception above. If the out-of-state physician agrees to diagnosis, counsel, or treat the patient directly, the patient must travel to the state where the physician is licensed, or the physician must obtain a license to practice medicine in the state where the patient is located.

Episodic and Follow-Up Care for Established Patients

Episodic Follow-Up Care

A patient that is temporarily located outside the jurisdiction of a physician with which the patient has an established relationship may receive care via telemedicine technologies provided it is possible for the physician to gather sufficient clinical information during the evaluation to provide care that meets the accepted standard of care. If the patient is presenting with new medical conditions, the physician may consider directing the patient to obtain local care.

If the physician becomes aware that the patient's out of state location is no longer temporary, the physician should similarly develop a plan to transition care to a physician licensed in the state where the patient is located. Physicians providing care under this exception should also be prepared to make referrals to a hospital or to a local specialist who can step in and assist, especially in cases of devolving medical or mental status.

Follow-up After Travel for Surgical/Medical Treatment

Due to the unavailability, rarity or severity of a diagnosis or necessary treatment, a patient may choose to travel specifically to obtain specialty care at a medical center located in another state. In this situation, a significant portion of the diagnosis and treatment of the patient should occur in the physician's state of licensure, to include but not limited to, a surgical or procedural intervention. After the workup, procedure, or treatment is performed, the patient may return to their own state of residence and require additional follow-up care. When this follow-up can be effectively provided virtually, physicians should be allowed to utilize telemedicine without obtaining a license to practice in the state where the patient resides. Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical condition make that necessary.

Clinical Trials

Physicians who work on clinical trials recruit patients based off certain criteria in hopes of increasing the likelihood of a successful and diverse clinical trial. When working on clinical trials that are enabled by telemedicine technologies, physicians should be not be precluded from including patients that reside in a state where the physician does not have a license to practice medicine. Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical condition make that necessary.

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Section Three. Standard of Care

A practitioner who uses telemedicine must meet the same standard of care and professional ethics as a practitioner using a traditional in-person encounter with a patient. The failure to follow the appropriate standard of care or professional ethics while using telemedicine may subject the practitioner to discipline by the medical board.

Scope of Practice

A practitioner who uses telemedicine should ensure that the services provided are consistent with the practitioner's scope of practice, including the practitioner's education, training, experience and ability. Physicians may supervise and delegate tasks via telemedicine technologies so long as doing so is consistent with applicable laws.

Establishment of a Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.[6] The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks care from a physician. The relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an in-person encounter between the physician (or other appropriately supervised health care practitioner) and patient. A physician-patient relationship may be established via either synchronous or asynchronous telemedicine technologies without any requirement of a prior in-person meeting, so long as the standard of care is met.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity, location, and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. If available, a patient should be able to select an identified physician for telemedicine services, not be assigned to a physician at random, and have access to follow-up care.

Evaluation and Treatment of the Patient

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or

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[6] American Medical Association, Council on Ethical and Judicial Affairs, *Fundamental Elements of the Patient-Physician Relationship (1990),* available at http://www.ama- assn.org/resources/doc/code-medical-ethics/1001a.pdf.

contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Gathering clinical history to make a diagnosis is often an iterative process and physicians need to have the opportunity and ability to ask iterative follow-up questions. If an evaluation requires additional ancillary diagnostic testing under the standard of care, the physician must complete such diagnostics, arrange for the patient to obtain the needed testing, or refer the patient to another provider. Additionally, as part of meeting the standard of care, physicians must use digital images, live video, or other modalities as needed to make a diagnosis if the standard of care in-person would have required physical examination. Treatment and consultation recommendations made in a virtual setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in in-person settings. Diagnosis, prescribing, or other treatment based solely on static online questionnaires, or those that do not obtain all of the information necessary to meet applicable standards of care, are not acceptable. Physicians practicing telemedicine utilizing adaptive questionnaires must have the ability to ask follow-up questions or obtain further history, especially when doing so is required to collect adequate information to appropriately diagnosis or treat.

Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of a traditional physical examination. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of a physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe.

Prescribing medications via telemedicine, as is the case during in-person care, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each prescription issued during a telemedicine encounter must be evaluated by the physician in accordance with state and federal laws, as well as current standards of practice, and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

<u>Informed Consent, Disclosure, and Functionality of Online Services Making Available Telemedicine Technologies</u>

Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient and the patient's location
- Identification of the physician, the physician's credentials, and the physician's state or territory of practice;
- Identification of the patient's primary care physician, if available;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, patient education, etc.);
- The patient agrees that the physician determines, in conjunction with applicable laws, whether or not the condition being diagnosed and/or treated is appropriate for a

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telemedicine encounter;

- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, enabling password protection of data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party, if consistent with state and federal law.

Physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated healthcare providers;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the online platform and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the online platform owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Physicians may choose to make health-related and non-health-related goods or products available to patients to meet a legitimate patient need in instances where the goods are medically necessary for patients and not immediately or reliably available to patients by other means. Physicians who choose to make goods available to patients should be cautioned that they must be mindful of the inherent power differential that characterizes the physician-patient relationship and therefore the significant potential for exploitation of patients. The principle of non-exploitation of patients also applies to scenarios involving physician-owned pharmacies located in practice offices. In such instances, physicians should offer patients freedom of choice in filling any prescriptions and must

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343 therefore allow prescriptions to be filled elsewhere.[7]
344
345 Continuity of Care and Referral for Emergent Situations
346 Patients should be able to seek, with relative ease, follow-up care or information from the physician
347 [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians
348 solely providing services using telemedicine technologies with no existing physician-patient
349 relationship prior to the encounter must make documentation of the encounter using telemedicine
350 technologies easily available to the patient and, subject to the patient's consent, any identified care
351 provider of the patient immediately after the encounter. Physicians have the responsibility to refer
352 patients for in-person follow-up care when a patient's medical issue requires an additional in-
353 person physical exam, diagnostic procedure, ancillary lab, or radiologic test.
354
355 If a patient is inappropriate for care via telemedicine technologies or experiences an emergent
356 situation, complication, or side effects after an encounter using telemedicine technologies,
357 physicians should have a standing plan in place and have the responsibility to refer the patient to
358 appropriate care (e.g. acute care, emergency room, or another provider) to ensure patient safety. It
359 is insufficient for physicians to simply refer all patients to the emergency department; each
360 situation should be evaluated on an individual basis and referred based on its severity and urgency.
361
362 Physicians have an obligation to support continuity of care for their patients. Terminating the
363 medical care of a patient without adequate notice or without making other arrangements for the
364 continued care of the patient may be considered patient abandonment or result in discipline from
365 the Board. A physician may not delegate responsibility for a patient's care to another person if the
366 physician knows, or has reason to know, that the person is not qualified to undertake responsibility
367 for the patient's care.
368
369 Medical Records
370 The medical record should include, if not required by law, copies of all patient-related electronic
371 communications, including patient-physician communication, prescriptions, laboratory and test
372 results, evaluations and consultations, records of past care, and instructions obtained or produced
373 in connection with the utilization of telemedicine technologies. Informed consents obtained in
374 connection with an encounter involving telemedicine technologies should also be filed in the
375 medical record. The patient record established during the use of telemedicine technologies must
376 be accessible and documented for both the physician and the patient, consistent with all established
377 laws and regulations governing patient healthcare records. Records should be in a format that is
378 easily transferable to the patient. If requested by the patient, physicians must share the medical
379 record with the patient's primary care physician and other relevant members of the patient's
380 existing care team.
381
382 Privacy and Security of Patient Records & Exchange of Information
383 Physicians should meet or exceed applicable federal and state legal requirements of medical/health
384 information privacy, including compliance with the Health Insurance Portability and
385 Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention

[7] FSMB. *Position Statement on Sale of Goods by Physicians and Physician Advertising*. April 2016, available at: https://www.fsmb.org/siteassets/advocacy/policies/position-statement-on-sale-of-goods-by-physicians-and-physician-advertising.pdf

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rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information" and "Confidentiality of Substance Use Disorder Patient Records," issued by the Department of Health and Human Services (HHS).[8,9] Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional in-person encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) healthcare personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory results must be secure within existing technology (i.e., password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

Section 4. Definitions

For the purposes of these guidelines, the following definitions apply:

"Consulting Physician" means a physician who evaluates a patient and relevant medical data or images, or other information, through telemedicine technologies upon recommendation of a referring physician.

"Patient Abandonment" means the termination of a health care physician-patient relationship without the assurance that an equal or higher level of care meeting the assessed needs of the patient's condition is present and available.

"Remote Patient Monitoring" means the use of synchronous or asynchronous electronic information and communication technology to collect personal health information and medical data from a patient in one location that is transmitted to a licensee in another location for use in the treatment and management of medical conditions that require frequent monitoring.

"Static Online Questionnaire" means an internet questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast with an adaptive, interactive, and responsive online interview.

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[8] *45 C.F.R. § 160, 164 (2000).*
[9] *42 C.F.R. Part 2 (2017).*

430 "Telemedicine" means the practice of medicine using electronic communications, information
431 technology or other means between a licensee in one location and a patient in another location,
432 with or without an intervening healthcare provider. Telemedicine is not an e-mail/instant
433 messaging conversation or fax-based interaction. It typically involves the application of secure
434 videoconferencing or store and forward technology to provide or support healthcare delivery by
435 replicating the interaction of a traditional, in-person encounter between a provider and a patient.
436 Telemedicine may include audio-only communications, but audio-only communications should
437 only be used as a substitute when a patient is unable or unwilling to access live-interactive
438 modalities or when audio-only interactions are considered the standard of care for the
439 corresponding healthcare service being delivered.
440
441 "Telemedicine Technologies" means technologies and devices enabling secure electronic
442 communications and information exchange between a licensee in one location and a patient in
443 another location, with or without an intervening healthcare provider.
444
445 **SECTION 2. Equity of Healthcare Access**
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447 When utilized and deployed effectively as a seamlessly integrated part of healthcare delivery,
448 telemedicine can improve access and reduce inequities in the delivery of healthcare. To be
449 effective, certain barriers must be eliminated or reduced, such as literacy gaps, access to broadband
450 internet, and coverage and payment of telemedicine services.
451
452 Education
453 Physicians, health systems, and other telemedicine providers should develop educational and
454 training information for patient groups with known limited digital literacy and access.
455
456 Broadband Internet
457 State governments should pursue policies to expand broadband access to all geographic regions,
458 including low-cost options to those communities that are unable to afford it.
459
460 Coverage and Payment
461 Limiting coverage may lead to additional inequities in the delivery of healthcare via
462 telemedicine. Health plans should provide coverage for the cost of healthcare services provided
463 through telemedicine on the same basis and to the same extent that the carrier is responsible for
464 coverage through in-person treatment or consultation. Health plans should not have separate
465 networks for telehealth or select telehealth providers.

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ADDITIONAL REFERENCES

12 Va. Admin. Code § 5-31-10

45 C.F.R. § 160, 164 (2000)

Alaska Admin. Code tit. 7, § 110.639

AMA. Council on Ethical and Judicial Affairs. *Code of Medical Ethics*.

AMA. *Report of the Council on Medical Service.* Addressing Equity in Telehealth. 7-CMS-21. (June 2021).

AMA. *Report of the Council on Medical Service*. Licensure and Telehealth. 8-CMS-21. (June 2021).

AOA. Policy Statement – Telemedicine. H601-A/17. (July 2017)

Ark. Code Ann. § 17-80-402(5)

Cal. Bus. & Prof. Code § 2290.5(d).

Center for Connected Health Policy. Impact of Audio-only Telephone in Delivering Health Services During COVID-19 and Prospects for Future Payment Policies & Medical Board Regulations. August 25, 2021.

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