

BOARD OF PHYSICAL THERAPY

Department of Health Professions

Perimeter Center

9960 Mayland Drive, Suite 200

Henrico, Virginia 23233

Hearing Room #3, Second Floor

Thursday, September 24, 2015

10:00 a.m.

Adhoc Committee – Telehealth

AGENDA

CALL TO ORDER – Allen R. Jones, Jr. PT, DPT, Chair

ORDER OF BUSINESS

- Discussion on Approach
- Review Literature – **TAB 1**
- Make Recommendations

Tab 1

FSBPT
Policy Recommendations



Federation of State Boards of Physical Therapy

Telehealth in Physical Therapy

Policy Recommendations for Appropriate Regulation

Approved April 2015 by FSBPT Board of Directors

1 Telehealth in Physical Therapy

2 Introduction

3 The Federation of State Boards of Physical Therapy (FSBPT or the Federation) is a membership
4 organization whose mission is to protect the public by providing service and leadership that promote
5 safe and competent physical therapy practice. Its membership comprises the 53 jurisdictional physical
6 therapy licensing boards in the United States.

7 Telehealth technology and applications are rapidly expanding. Telehealth technology often uses secure
8 videoconferencing or 'store and forward' technology to allow interaction between the patient/client
9 ("client") and the healthcare provider. In some cases, such as when travel is difficult or there is no
10 provider nearby, the use of the technology is preferable to a traditional (in-person) encounter. The
11 provider, however, is responsible for making sure that the appropriate care can be delivered without in-
12 person interaction.

13 Advancement in telehealth may be complicated by current regulatory requirements, assumptions,
14 and/or licensure policies. Some of the difficulty to provide physical therapy services using telehealth
15 technologies may be related to the current fragmented licensure system. Inconsistent licensure
16 application requirements and the necessity to obtain licensure (licensure or certification in the case of
17 the PTA) in every state in which clients are located may be viewed as potential barriers to providing
18 physical therapy services remotely. Concerns have been voiced in the regulatory community regarding
19 the potential in telehealth for the misuse of physical therapist assistants (PTAs), the potential for
20 fraudulent billing, as well as other unprofessional conduct. Mandates for in-person evaluations or
21 supervisory visits are examples of regulations, while well intentioned, may inhibit the potential use of
22 telehealth in physical therapy.

23 While researching licensure mobility, FSBPT took note of the interest in telehealth in reference
24 literature, legislative initiatives, popular media, as well as FSBPT member requests for information and
25 resources regarding regulation of physical therapy services utilizing telehealth technology. As a first
26 step, FSBPT reviewed the existing 5th Edition of the Model Practice Act (MPA) language which defines
27 telehealth as "*the use of electronic communications to provide and deliver a host of health-related*
28 *information and healthcare services (including physical therapy related information and services) over*
29 *large and small distances.*" As we further researched typical applications of telehealth in varied
30 treatment settings, we found that the use of telehealth was growing significantly in the profession yet
31 questions remained regarding the best practices for regulation.

32 The purpose of this document is to provide information and general guidance to physical therapy
33 jurisdictional authorities for regulating the use of telehealth technologies in the practice of physical
34 therapy. In developing these recommendations, FSBPT conducted a review of other professions' models
35 and best practices, telehealth nomenclature, published practice/clinical guidelines, and industry
36 standards. Acknowledging the rapid growth in telehealth technology and applications, the guidelines in
37 this resource were purposefully written in a general manner in an attempt to maintain future relevance

75 or drivers license number does not have to be shared or revealed. The client may utilize current means,
76 such as state websites, to verify the physical therapy provider is licensed in the originating jurisdiction
77 (where the client is located and receiving telehealth services).

78 **Informed consent**

79 Just as PTs must follow state law requirements and professional best practices for acquiring informed
80 consent for in-person encounters, the same requirements should be followed for the delivery of physical
81 therapy services via telehealth technologies. Clients should be made aware of any limitations that
82 telehealth services present as compared to an in-person encounter for that client's situation such as the
83 inability to perform hands-on examination, assessment and treatment. Given the unique nature of the
84 provision of services through telehealth there are some special considerations including:

- 85 1. Consent to being photographed, recorded, or videotaped and consent to the storage of the
86 encounter data, if applicable. Disclosure should be made as to how long data will be stored.
- 87 2. Consent procedures should include a hold harmless clause for medical or other information lost
88 because of technology failures. Clients should be informed of the possibility of failure of the
89 technologies used to provide telehealth services.

90 **Physical therapist/client relationship**

91 Developing a physical therapist/client relationship is relevant regardless of the delivery method of the
92 physical therapy services. As alternative delivery methods such as telehealth emerge, it bears stating
93 that the PT/client relationship can be established in the absence of actual physical contact between the
94 PT and client. Just as in a traditional (in-person) encounter, once the relationship is established, the
95 therapist has an obligation to adhere to the reasonable standards of care for the patient (duty of care).
96 Guidelines, position statements, or standards for telehealth developed by a professional organization or
97 society (e.g. American Physical Therapy Association (APTA), American Telemedicine Association (ATA)),
98 should be reviewed and appropriately incorporated into practice.

99 **Licensure**

100 Physical therapy providers delivering care using technology must be authorized by law (licensure or
101 certification) to provide physical therapy services in the state or jurisdiction in which the client is
102 physically located during the PT/client interaction. This originating site, or client site, is the location
103 where physical therapy care occurs. The client site may change if the client's physical location changes
104 between initial and subsequent treatments. The provider must be licensed in the jurisdiction where the
105 client is located and must adhere to the laws defining scope of practice in that jurisdiction, however, the
106 provider should not be required to be physically located in that same jurisdiction. The physical therapy
107 providers should ensure compliance with regulatory requirements as applicable.

108 **Standards of care**

109 It is the responsibility of the PT to ensure the standard of care required both professionally and legally
110 per the practice act is met. As such, it is incumbent upon the PT to determine which clients and
111 therapeutic interventions are appropriate for the utilization of technology as a component of, or in lieu
112 of, in-person provision of physical therapy care. Physical therapy providers shall be guided by

150 is available and functioning properly and all personnel are trained in equipment operation,
151 troubleshooting, and necessary hardware/software updates. Additionally, arrangements should be
152 made to ensure access to appropriate technological support as needed.

153 **Emergencies and Client Safety Procedures**

154 When providing physical therapy services, it is essential to have procedures in place to address
155 technical, medical, or clinical emergencies. Emergency procedures need to take into account local
156 emergency plans as medical emergencies will most often be handled through the typical chain of
157 emergency procedures such as notifying the client’s emergency contact, notifying local physician, or
158 calling local first responders. Alternate methods of communication between both parties should be
159 established prior to providing telehealth services in case of technical complications. It is the
160 responsibility of the provider to inform the client of these procedures; furthermore, it is the
161 responsibility of the provider to have all needed information to activate emergency medical services to
162 the clients’ physical location if needed at time of the services are being provided. If during the provision
163 of services the provider feels that the client might be experiencing any medical or clinical complications
164 or emergencies, services will be terminated and the client referred to an appropriate level of service.

165 **Conclusion**

166 Advancements in technology have created expanded and innovative treatment options for clinicians and
167 clients while posing challenges to physical therapy regulators. The delivery of physical therapy services
168 by or under the supervision of a physical therapist via telehealth is physical therapy, falling under the
169 purview of the existing regulatory body and the respective practice act and regulations. Regulators must
170 consider care delivered in this manner as physical therapy first, telehealth second; ignoring any impulse
171 to draft a new set of “telehealth” rules, instead, relying on the existing regulatory framework for
172 physical therapy and making minor modifications as needed.

173

174 FSBPT Ethics & Legislation Committee Members

175 Jane E. Julian, PT/ATC

176 Joni Kalis, PT, MS

177 Kevin Lindsey, PT

178 Kathleen A. Luedtke-Hoffmann, PT, MBA, PhD

179 Scott D. Majors

180 Robert E. Schmidt, PT

181

- 216 Mead v Adler, 321 OR App 451, Oregon Court of Appeals (October 29, 2009).
- 217 *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*,
218 Federation of State Medical Boards, April 2014.
- 219 *The Model Practice Act for Physical Therapy. A Tool for Public Protection and Legislative Change. 4th*
220 *edition*, Federation of State Boards of Physical Therapy, 2006.
- 221 New York State Department of Health, Special Committee on Telemedicine, “Statements on
222 Telemedicine Board of Professional Medical Conduct.”
- 223 O’Connor, M, “The Physician-Client Relationship & the Professional Standard of Care: Reevaluation
224 Medical Negligence Principles to Achieve the Goals of Tort Reform,” American Bar Association Tort Trial
225 and Insurance Practice Section, Law Student Writing Competition 2009-2010 First Prize Winner.
- 226 Olanrewaju, R.F, Ali, Norashikin Bte., Khalifa, O, and AbdManaf, A., “ICT in Telemedicine: Conquering
227 Privacy and Security Issues in Health Care Services,” *Department of Electrical & Computer Engineering*,
228 *Faculty of Engineering, International Islamic University Malaysia*, www.Academia.edu.
- 229 Sanbar, S., “Formation of the Physician-Client Relationship: Contract-Based and Tort-Based
230 Approaches,” *A Day With the Judges*, Oklahoma City, Oklahoma, 2010.
- 231 Simon, RI and Shuman D.W., “The Doctor-Client Relationship,” *Clinical Manual of Psychiatry and Law*,
232 American Psychiatric Publishing, Arlington, Virginia, 2007, <http://FOCUS.psychiatryonline.org/journal>.
- 233 *Telenursing Practice Guidelines*, College of Registered Nurses of Nova Scotia, 2008.
- 234 Torres, A.W., “Establishing the Physician-client Relationship,” *J Dermatol Surg Oncol*, 19(2), 1993, pp.
235 147-149.

NCSBN

Position Paper on

Telehealth Nursing Practice

The National Council of State Boards of Nursing (NCSBN®) Position Paper on Telehealth Nursing Practice

Approved August 1997 by the Delegate Assembly

Editorial Update - April 2014

In the 1990s the increasing use of telecommunication technology to provide nursing services raised the question whether nursing services delivered through broadband and electronic channels constituted the practice of nursing. NCSBN recognizes nursing practice provided through broadband and electronic channels as the practice of nursing and thus asserts that the regulation of telehealth nursing is appropriately done by boards of nursing (BONs).

Telehealth nursing practice is defined as the practice of nursing delivered through various telecommunications technologies, including high speed Internet, wireless, satellite and televideo communications. The nurse engages in the practice of nursing by interacting with a client at a remote site to electronically receive the client's health status, initiate and transmit therapeutic interventions and regimens, and monitor and record the client's response and nursing care outcomes. The value of telehealth to the client is increased access to skilled, empathetic and effective nursing delivered through telecommunications technology.

Much of the debate 20 years ago focused on nursing by telephone. The nurse uses the televideo, email and other two-way telecommunication modalities to gather information from the client and to give appropriate advice based on a nursing diagnosis or medical protocol. Some providers pose that this is not nursing practice; however, all U.S. jurisdictions and many professional associations agree that if nursing services are delivered, nursing practice has occurred. How nursing services are delivered makes no difference. The challenge to regulation is to identify how nursing care can be safely and effectively delivered using telecommunications technology.

Telehealth is utilized by health care systems as a means for reducing health care costs by making it possible to spread the benefit of limited resources to a large population over a broad geographic region. Managed care organizations and demand-management companies are providing person-to-person contact via nurse telephone advice services. An issue for regulators is how does the caller know that the individual who receives the call is a nurse? Is the public expectation that identification by name and credential is required? If so, how is this verified?

Televideo and Internet support groups facilitated by nurses provide emotional and informational support to clients and families. To have an electronic presence to dispel isolation occurs through client-activated alert mechanisms and physical monitoring devices, such as remote telemetry. Does the client or public know the standards that nurses using this modality should be expected to meet and maintain? Does the public know how to report the failure of the nurse facilitator or nurse monitor to provide nursing practice with reasonable skill and safety?

The teaching-coaching embedded in skilled nursing care is perhaps the most readily recognized function which may be carried out using telecommunications. Because clients frequently check out their questions with the nurse before asking the physician, health care delivery systems have implemented "Ask a Nurse" televideo lines. Postdischarge telephone follow-up and Internet access to a nurse assists clients to "integrate" illness and recovery into their lifestyles. The regulatory community needs to address the patient's control or input regarding information and access, as well as the appropriateness of the type and level of information that is accessible.

Combining effective management of rapidly changing situations with the diagnostic and monitoring function is demonstrated by the well-established practice of televideo triage nursing and remote sensory collection devices. Televideo triage involves prioritizing a client's health problems according to their urgency, educating and advising clients, and making safe, effective and appropriate dispositions. Health care organizations use nurses for televideo triage to assess the patient's potential for wellness and response to various treatment strategies as a mechanism to reduce hospitalizations. This type of practice requires the use of electronic medical records.

The nurse's role in the implementation of medical regimens is also accomplished using telehealth. The electronic implementation of medical protocols or guidelines to achieve certain client health outcomes is an established delivery model. Nurses are expected to use professional judgment to carry them out by assessing what can be safely omitted from or added to medical orders, and by getting appropriate and timely responses from physicians in order to monitor and ensure the quality of health care practices. Interactive video technology using high speed infrastructure is used by nurses manipulating electronic sensors and interacting with a physician at a remote site to carry out such delegated medical functions as taking X-rays, suturing wounds and setting fractures. BONs and the medical practice must collaboratively identify the responsibility and accountability of practitioners in this interactive practice.

Another example of telehealth nursing practice is the use of interactive video devices via high speed Internet by home health care nurses to provide a means to detect any early warning signals for client complications. The nurse can use remote visual, auditory and tactile sensors, manipulated by the client or family members, to assess the client. Complications, such as breakdown and deterioration, can be anticipated or detected early, prior to confirming diagnostic signs. The data are transmitted electronically so the nurse can detect and document significant changes in a client's condition. Crisis televideo hotlines are used by nurses to identify and manage client crises until other assistance is available.

Often the client is located in one state and the nurse in another jurisdiction. What are the regulatory concerns for practice across state lines? Does the nurse need to be licensed in both states? The functional domains described thus far are examples of how nurses use telecommunications technology to deliver cognitive nursing care. Data are collected, interpreted and analyzed to develop a working diagnosis and plan. The plan is initiated by instructing the client how or where the treatment should occur.

The potential to administer and monitor therapeutic interventions and regimens is significant. Robotic range of motion may be implemented by continuous passive motion devices applied by the client or family member and remotely electronically controlled. Intravenous therapy may be similarly implemented. Through means of mobile broadband and cellular connectivity a client in a rural area is able to automatically transmit data from the client's insulin pump to a computer in a medical center. The data are compared with the client's blood sugar level, the pump's output is recalibrated and the new data are transmitted to the computer chip in the pump. This same technology is used to administer medications accurately and safely, and to monitor untoward effects, reactions, therapeutic responses, toxicity and incompatibilities.

These examples of telehealth nursing practice presented are not intended to be definitive of nursing practice, but rather are descriptive of how the practice of nursing may be carried out electronically using telecommunications technology. This list provides examples of telehealth nursing practice and is not intended to be exhaustive. Telecommunications is advancing at such a rapid rate that its application to health care delivery and nursing practice will continue to emerge and evolve.

Telecommunications and information technology have brought forward new situations and challenges to nursing regulators. The first step in resolving these regulatory concerns is to answer the question, "Does the provision of nursing services through electronic transmission constitute the practice of nursing?" Affirmatively, "Yes." The delivery of nursing services through the Internet or any other electronic channels constitutes the practice of nursing.

Telehealth is the remote delivery of healthcare services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite and telephone media.

-American Telemedicine Association, 2014

HB 2063 – Approved 3/16/15

[history](#) | [hilite](#) | [pdf](#)**CHAPTER 115**

An Act to amend and reenact §§ 38.2-3418.16 and 54.1-3303 of the Code of Virginia, relating to the provision of health care services through telemedicine services.

[H 2063]

Approved March 16, 2015

Be it enacted by the General Assembly of Virginia:

1. That §§ ~~38.2-3418.16~~ and ~~54.1-3303~~ of the Code of Virginia are amended and reenacted as follows:

§ ~~38.2-3418.16~~. Coverage for telemedicine services.

A. Notwithstanding the provisions of § ~~38.2-3419~~, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

B. As used in this section, "telemedicine services," as it pertains to the delivery of health care services, means the use of *electronic technology or media, including interactive audio, or video, or other electronic media used for the purpose of diagnosis, consultation, diagnosing or treatment treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment.* "Telemedicine services" ~~do~~ does not include an audio-only telephone, electronic mail message, ~~or~~ facsimile transmission, *or online questionnaire.*

C. An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

D. An insurer, corporation, or health maintenance organization shall not be required to reimburse the treating provider or the consulting provider for technical fees or costs for the provision of telemedicine services; however, such insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through face-to-face consultation or contact.

E. Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require pre-authorization of emergent telemedicine services.

F. An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through face-to-face diagnosis, consultation, or treatment.

G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

H. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2011, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

I. This section shall not apply to short-term travel, accident-only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only.

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, or by a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32. The prescription shall be issued for a medicinal or therapeutic purpose and may be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship.

For purposes of this section, a bona fide practitioner-patient-pharmacist relationship is one in which a practitioner prescribes, and a pharmacist dispenses, controlled substances in good faith to his patient for a medicinal or therapeutic purpose within the course of his professional practice. In addition, a bona fide practitioner-patient relationship means that the practitioner shall (i) ensure that a medical or drug history is obtained; (ii) provide information to the patient about the benefits and risks of the drug being prescribed; (iii) perform or have performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically; except for medical emergencies, the examination of the patient shall have been performed by the practitioner himself, within the group in which he practices, or by a consulting practitioner prior to issuing a prescription; and (iv) initiate additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects.

For the purpose of prescribing a Schedule VI controlled substance to a patient via telemedicine services as defined in § 38.2-3418.16, a prescriber may establish a bona fide practitioner-patient relationship by an examination through face-to-face interactive, two-way, real-time communications services or store-and-forward technologies when all of the following conditions are met: (a) the patient has provided a medical history that is available for review by the prescriber; (b) the prescriber obtains an updated medical history at the time of prescribing; (c) the prescriber makes a diagnosis at the time of prescribing; (d) the prescriber conforms to the standard of care expected of in-person care as appropriate to the patient's age and presenting condition, including when the standard of care requires the use of diagnostic testing and performance of a physical examination, which may be carried out through the use of peripheral devices appropriate to the patient's condition; (e) the prescriber is actively licensed in the Commonwealth and authorized to prescribe; (f) if the patient is a member or enrollee of a health plan or carrier, the prescriber has been credentialed by the health plan or carrier as a participating provider and the diagnosing and prescribing meets the qualifications for reimbursement by the health plan or carrier pursuant to § 38.2-3418.16; and (g) upon request, the prescriber provides patient records in a timely manner in accordance with the provisions of § 32.1-127.1:03 and all other state and federal laws and regulations. Nothing in this paragraph shall permit a prescriber to establish a bona fide practitioner-patient relationship for the purpose of prescribing a Schedule VI controlled substance when the standard of care dictates that an in-person physical examination is necessary for diagnosis. Nothing in this paragraph shall apply to: (1) a prescriber providing on-call coverage per an agreement with another prescriber or his prescriber's professional entity or employer; (2) a prescriber consulting with another prescriber regarding a patient's care; or (3) orders of prescribers for hospital out-patients or in-patients.

Any practitioner who prescribes any controlled substance with the knowledge that the controlled substance will be used otherwise than medically or for therapeutic purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the distribution or possession of controlled substances.

B. In order to determine whether a prescription that appears questionable to the pharmacist results from a bona fide practitioner-patient relationship, the pharmacist shall contact the prescribing practitioner or his agent and verify the identity of the patient and name and quantity of the drug prescribed. The person knowingly filling an invalid prescription shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the sale, distribution or possession of controlled substances.

No prescription shall be filled unless there is a bona fide practitioner-patient-pharmacist relationship. A prescription not issued in the usual course of treatment or for authorized research is not a valid prescription.

C. Notwithstanding any provision of law to the contrary and consistent with recommendations of the Centers for Disease Control and Prevention or the Department of Health, a practitioner may prescribe Schedule VI antibiotics and antiviral agents to other persons in close contact with a diagnosed patient when (i) the practitioner meets all requirements of a bona fide practitioner-patient relationship, as defined in subsection A, with the diagnosed patient; (ii) in the practitioner's professional judgment, the practitioner deems there is urgency to begin treatment to prevent the transmission of a communicable disease; (iii) the practitioner has met all requirements of a bona fide practitioner-patient relationship, as defined in subsection A, for the close contact except for the physical examination required in clause (iii) of subsection A; and (iv) when such emergency treatment is necessary to prevent imminent risk of death, life-threatening illness, or serious disability.

D. A pharmacist may dispense a controlled substance pursuant to a prescription of an out-of-state practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine authorized to issue such prescription if the prescription complies with the requirements of this chapter and ~~Chapter 34 the Drug Control Act~~ (§ ~~54.1-3400~~ et seq.), known as the "Drug Control Act."

E. A licensed nurse practitioner who is authorized to prescribe controlled substances pursuant to § ~~54.1-2957.01~~ may issue prescriptions or provide manufacturers' professional samples for controlled substances and devices as set forth in ~~Chapter 34 the Drug Control Act~~ (§ ~~54.1-3400~~ et seq.) in good faith to his patient for a medicinal or therapeutic purpose within the scope of his professional practice.

F. A licensed physician assistant who is authorized to prescribe controlled substances pursuant to § ~~54.1-2952.1~~ may issue prescriptions or provide manufacturers' professional samples for controlled substances and devices as set forth in ~~Chapter 34 the Drug Control Act~~ (§ ~~54.1-3400~~ et seq.) in good faith to his patient for a medicinal or therapeutic purpose within the scope of his professional practice.

G. A TPA-certified optometrist who is authorized to prescribe controlled substances pursuant to Article 5 (§ ~~54.1-3222~~ et seq.) of Chapter 32 may issue prescriptions in good faith or provide manufacturers' professional samples to his patients for medicinal or therapeutic purposes within the scope of his professional practice for the drugs specified on the TPA-Formulary, established pursuant to § ~~54.1-3223~~, which shall be limited to (i) oral analgesics included in Schedules III through VI, as defined in §§ ~~54.1-3450~~ and ~~54.1-3455~~ of the Drug Control Act (§ ~~54.1-3400~~ et seq.), which are appropriate to relieve ocular pain, (ii) other oral Schedule VI controlled substances, as defined in § ~~54.1-3455~~ of the Drug Control Act, appropriate to treat diseases and abnormal conditions of the human eye and its adnexa, (iii) topically applied Schedule VI drugs, as defined in § ~~54.1-3455~~ of the Drug Control Act, and (iv) intramuscular administration of epinephrine for treatment of emergency cases of anaphylactic shock.

H. The requirement for a bona fide practitioner-patient relationship shall be deemed to be satisfied by a member or committee of a hospital's medical staff when approving a standing order or protocol for the administration of influenza vaccinations and pneumococcal vaccinations in a hospital in compliance with § ~~32.1-126.4~~.

Legislative Information System

Virginia Board of Medicine

Guidance Document 85-12

Telemedicine

Virginia Board of Medicine

Telemedicine

Section One: Preamble.

The Virginia Board of Medicine ("Board") recognizes that using telemedicine services in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these services can enhance medical care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice. The Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services. The Board issues this guidance document to assist practitioners with the application of current laws to telemedicine service practices.

These guidelines should not be construed to 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 authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. For clarity, a practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303 and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine services in the practice of medicine. The Board is committed to ensuring patient access to the convenience and benefits afforded by telemedicine services, while promoting the responsible provision of health care services.

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

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the applicable profession;
- Adhere to applicable laws and regulations;
- In the case of physicians, properly supervise non-physician clinicians when required to do so by statute; and
- Protect patient confidentiality.

Section Two: Definitions.

For the purpose of these guidelines, “telemedicine services” shall be defined as it is in HB 2063,¹ which was approved by the Virginia General Assembly as an amendment to § 38.2-3418.16 of the Code of Virginia. Under that definition,

“telemedicine services,” as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient’s diagnosis or treatment. “Telemedicine services” does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

Va. Code § 38.2-3418.16 (as amended by HB 2063).²

Section Three: Establishing the Practitioner-Patient Relationship.

The practitioner-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship.

Where an existing practitioner-patient relationship is not present,³ a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law.⁴ While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.

Specifically, Virginia Code § 54.1-3303(A) provides the requirements to establish a practitioner-patient relationship. *See* Va. Code § 54.1-3303(A).⁵

A practitioner is discouraged from rendering medical advice and/or care using telemedicine services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner’s identity 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 services. An appropriate practitioner-patient relationship has not been established when the identity of the practitioner may be unknown to the patient.

¹ HB 2063 amended Virginia Code §§ 38.2-3418.16 and 54.1-3303. HB2063 was passed by the Virginia General Assembly during the 2015 Legislative Session and, if signed by the governor, will become law on July 1, 2015.

² The Board reserves the right to revisit these Guidelines and in particular this definition should the General Assembly further alter the statutory definition of “telemedicine services” or authorize the Board to provide a definition of telemedicine or telehealth.

³ This guidance document is not intended to address existing patient-practitioner relationships established through in-person visits.

⁴ The practitioner must adhere not only to Virginia law defining a practitioner-patient relationship, but the law in any state where a patient is receiving services that defines the practitioner-patient relationship.

⁵ By passing HB 2063, the General Assembly amended Virginia Code § 54.1-3303(A), which amendment specifically addresses the establishment of a patient-practitioner relationship for the purposes of prescribing Schedule VI controlled substances via telemedicine services. Once signed by the governor, this amendment will become law on July 1, 2015. All licensees are responsible for ensuring and maintaining compliance with applicable laws.

Section Four: Guidelines for the Appropriate Use of Telemedicine Services.

The Board has adopted the following guidelines for practitioners utilizing telemedicine services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.

Licensure:

The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

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 contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, which treatment includes the issuance of prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional, in-person encounters. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:

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

- Identification of the patient, the practitioner, and the practitioner's credentials;
- Types of activities permitted using telemedicine services (e.g. prescription refills, appointment scheduling, patient education, etc.);
- Agreement by the patient that it is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine services, such as encrypting date of service, password protected screen savers, encrypting 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.

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-practitioner communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine services. Informed consents obtained in connection with an encounter involving telemedicine services should also be filed in the medical record. The patient record established during the use of telemedicine services must be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records and Exchange of Information:

Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using telemedicine services. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner 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.

Prescribing:

Prescribing medications, in-person or via telemedicine services, is at the professional discretion of the prescribing practitioner. The indication, appropriateness, and safety considerations for each prescription provided via telemedicine services must be evaluated by the practitioner in accordance with applicable law and current standards of practice and consequently carries the same professional accountability as prescriptions delivered during an in-person encounter. Where such measures are upheld, and the appropriate clinical consideration is carried out and documented, the practitioner may exercise their judgment and prescribe medications as part of telemedicine encounters in accordance with applicable state and federal law.

Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A) as amended by HB 2063. Additionally, practitioners issuing prescriptions as part of telemedicine services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship.

Section Five: Guidance Document Limitations.

Nothing in this document shall be construed to limit the authority of the Board to investigate, discipline, or regulate its licensees pursuant to applicable Virginia statutes and regulations. Additionally, nothing in this document shall be construed to limit the Board's ability to review the delivery or use of telemedicine services by its licensees for adherence to the standard of care

and compliance with the requirements set forth in the laws and regulations of the Commonwealth of Virginia. Furthermore, this document does not limit the Board's ability to determine that certain situations fail to meet the standard of care or standards set forth in laws and regulations despite technical adherence to the guidance produced herein.