Telemedicine is increasingly a hot topic among health care providers, organizations and patients. Whether for better access to physicians, referrals, second opinions or remote consultations, both physicians and patients alike favor increased communication via electronic methods. Reimbursement for telecommunication encounters is on the rise and more health plans are encouraging it. Whether the modality is via your smart phone, tablet, laptop, computer or telephone, the growing popularity of telemedicine warrants a look at risk management, insurance and regulation issues.

The very definition of telemedicine is evolving along with its technology, regulations and practice guidelines. Undoubtedly we will see more of it in the future as reimbursement for telemedicine encounters, physician accessibility and consumer preference for it increase. So what is it and what are the liability, insurance and risk management issues involved with this evolving practice?

Definitions and Background

There is no one standard definition for telemedicine, but generally, the term refers to any medical activity that occurs at a distance using some form of telecommunication. In some states, telemedicine encompasses exchanges by telephone, fax and email.

The Centers for Medicare and Medicaid Services (CMS) defines telemedicine as ‘a two-way, real-time interactive communication between a patient and a physician or practitioner at a distant site through telecommunications equipment that includes, at a minimum, audio and visual equipment.’

The American Telemedicine Association (ATA) defines telemedicine as ‘the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment and services.’

Whatever the definition, telemedicine certainly involves patient-physician encounters via computer, camera, smart phone, tablet, telephone, email, fax – or whatever may develop in the future that allows interaction that is not face to face. The absence of a face-to-face encounter has many concerned that professional liability will increase because diagnostic capabilities are limited.
The ATA notes that telemedicine is not a separate medical specialty. Products and services related to telemedicine are often part of a larger investment by health care institutions in either information technology or the delivery of care. Even with respect to reimbursement, there is generally no distinction made between services delivered on site and those delivered via telemedicine; there is often no separate coding for billing of remote services.³

The principal services available through telemedicine fall into four categories:

- **Primary care and specialist referral services** may involve a primary care physician, allied health professional or specialist consultation with a patient in rendering a diagnosis, either through live interactive video or use of digitally stored and forwarded diagnostic images, vital signs, video clips and/or patient data.

- **Remote patient monitoring** includes home telehealth, using devices to remotely collect and monitor data for a specific vital sign; for instance, blood glucose, ECG or other indicators for a homebound patient, sent to a remote diagnostic testing facility, or a more sophisticated application, such as intraoperative neuromonitoring during orthopedic, neurological and neurovascular surgery.

- **Consumer medical and health information** means that consumers access specialized health information and online discussion groups on the internet via wireless devices.

- **Medical education** provides continuing medical education credits for health care professionals and specialized medical seminars for providers in remote locations.

The ATA references four fundamental benefits of telemedicine:

- **Improved Access** – Bringing health care services to patients in distant locations and allowing physicians and health facilities to expand their geographic reach.

- **Cost Efficiencies** – Reducing the cost to patients and payers of accessing both primary and specialist care, and increased efficiencies in the management of chronic diseases.

- **Improved Quality** – Studies have shown the quality of health care services delivered via telemedicine is equivalent to that of in-person consultations; in some specialties telemedicine has been demonstrated to deliver a superior product, with better outcomes and greater patient satisfaction.

- **Patient Demand** – Meeting increasing consumer demand for access and efficiency, reducing travel time and stress for patients and their families.⁴

## CHANGING LANDSCAPE

### PRACTICE GUIDELINES

Telemedicine practice guidelines published by the ATA and the AMA outline specific protocols and practice parameters for physicians. In general, they suggest the importance of establishing a physician/patient relationship and using the standard of care common to face-to-face patient encounters. Issues addressed in the guidelines include:

- Referrals and emergencies
- Physical exam
- Informed consent and teaching
- Telemedicine patient management
- Quality reviews
- Provider training
- Documentation
- Follow-up
- Regulatory compliance
- Home monitoring
REGULATIONS, LICENSING, REIMBURSEMENT AND JURISDICTIONAL CONFLICTS

Regulations concerning licensing of telemedicine and reimbursement for services under both private insurance and government-funded programs, Medicaid in particular, are currently a mosaic across the 50 states and the District of Columbia. The permutations and intricacies, especially for multi-state telemedicine providers, require careful, individual analysis in consultation with legal counsel and are beyond the scope of this article.

For example, the American Medical Association has highlighted the practice of prescribing medication as one important topic that is a source of confusion. While state regulations vary, the general consensus, supported by the AMA, is that care provided by telemedicine needs to meet the same standard of care as care provided in person. At a minimum, this requires an established patient-physician relationship before any prescriptions are issued. AMA supports the use of telemedicine for prescribing, but AMA policy makes it clear that the physician (or other authorized provider) must first establish the patient-physician relationship.

The ‘patient-physician relationship’ is described in the AMA Code of Ethics simply and somewhat ambiguously as one ‘that exists when a physician serves a patient’s medical needs.’ However, AMA policy further requires that establishing the patient-physician relationship includes obtaining a medical history, describing treatment risks, benefits and options, arranging for appropriate follow-up care, maintaining health records and recording any prescriptions issued in the patient’s file.

Through its Council on Medical Service (called CMS, not to be confused with the Centers for Medicare/Medicaid Services, also ‘CMS’), the AMA has clarified its policy to state that ‘prior to delivering services via telemedicine, a valid patient-physician relationship must be established through, at minimum, a face-to-face examination.’ The face-to-face encounter could occur in person or virtually, through real-time audio and visual technology. Thus, issuing prescriptions based on a relationship established solely via an online questionnaire is ethically prohibited.

AMA policy likewise requires the face-to-face encounter (virtual or in person) as a component of establishing the patient relationship when consultation is with another physician who has a patient-physician relationship. Exceptions are recognized for situations, such as emergency medical treatment, on-call coverage and cross-coverage. The Federation of State Medical Boards (FSMB) has a model policy on telemedicine that is similar to the AMA’s policy.

Even with the ethical relationship established, telemedicine providers still must abide by appropriate licensing and credentialing requirements. Physicians who use telemedicine to practice across state lines must have in most instances a full, unrestricted license in the state where the patient is located, as well as in the state where the provider is located. However, certain states have established limited licensing for telemedicine, e.g., AL, LA, MN, MT, NM, OH, OR, TN and TX. The limited licenses allow physicians to practice across state lines without obtaining a full license in each state where patients are located, based on the patient being located in the state that issues the limited license, and the practitioner being fully licensed in the practitioner’s home state.

Additionally, the FSMB has proposed a multi-state compact to allow multi-state licensing for physicians board-certified in one state to have their licenses reciprocally recognized in other states without having to apply for full licensure in other states. This compact would apply to telemedicine, in addition to in-person practice.

The following examples illustrate the range of state laws and regulations governing telemedicine:

- **California**: Physicians who use telemedicine are held to the same standard of care as if they treated the patient in person. Before beginning any telemedicine procedures, the patient must verbally consent, and this consent must be noted in the patient’s file.

- **Florida**: Florida also requires the same standard of care that applies to in-person encounters. Any technology used must convey the same information needed to meet the standard of care; physicians are responsible for the quality of this technology. Patient-physician relationships can be established via telemedicine alone (no in-person encounter required), but controlled substances may not be prescribed via telemedicine.
**New Hampshire:** Telemedicine is controlled by the same regulations as the general practice of medicine, making New Hampshire’s law among the strictest in the country regulating the use of telemedicine. Therefore, a patient-physician relationship can only be established with an in-person exam, history, diagnosis, treatment plan and prescriptions. An exception to the in-person requirements is made for the practice of teleradiology; however, any out-of-state physician practicing teleradiology on patients located in New Hampshire must be licensed to practice medicine in New Hampshire.15

**Hawaii:** The only requirement for telemedicine is that it meets the necessary standard of care – the other end of the spectrum! Prescriptions via telemedicine are treated as if they were issued in connection with an in-person encounter.16

**Texas:** Texas law is specific with respect to a variety of telemedicine scenarios. A distinction is made between telemedicine services provided to a patient who is at an established medical site, and telemedicine services provided to a patient who is not at an established medical site.17 An ‘established site’ means a location where there is a ‘patient site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation, as appropriate for the patient’s presenting complaint’ and does not include a private residence.18 If the patient is at an established medical site and distant-site physician may use telemedicine to establish a patient relationship, diagnose and treat.19 If the patient is not at an established medical site, Texas law requires that the physician and patient have had at least one face-to-face encounter before treatment can be provided, including issuing prescriptions, with the initial encounter being either in-person or remotely at an established medical site.20

However, controversy has arisen in Texas over the use of telemedicine and the face-to-face encounter. On April 10, 2015, the Texas Medical Board adopted a strict rule, effective June 1, 2015, requiring an in-person visit by a patient with a physician before providing diagnosis or prescribing drugs by phone or video. (Prior to June 1, the rules allowed telemedicine without a prior visit if a patient was at a health facility, such as a hospital, clinic or pharmacy, and had another health care professional with them, as well as providing an exception for mental health visits.)

A well-established online and telephonic physician service, Teladoc, based in Dallas, filed a federal anti-trust suit against the Board on April 29. (Teladoc has completed more than 600,000 consultations, including 140,000 in Texas over the past 10 years, many of them on nights, weekends and holidays.) On May 29, U.S. District Judge Robert Pittman issued a temporary injunction blocking the implementation of the new rules, pending a trial on the issues. The Texas Medical Board contends the rules are necessary to ensure patient safety, while Teladoc, which has been at odds with the Board since 2011, contends the rules are an illegal restraint of trade designed mainly to protect the financial interests of physicians. This will be a case worth watching for its potentially broader implications nationally.

With respect to reimbursement under both Medicaid and private insurance for telemedicine services, the law is clearly moving in the direction of promoting the use of telemedicine. This trend has accelerated since the passage of the ACA. Currently, nine states and the District of Columbia have laws mandating coverage and reimbursement for telemedicine services under their Medicaid programs: CA, CO, KY, MD, MN, MS, NE, TX, VT, DC.

With respect to private insurance, as of 2015, 27 states and DC, covering nearly half the U.S. population, have ‘parity laws’ for private insurance coverage of telemedicine: AZ, AR, CA, CO, DC, GA, HI, IN, KY, LA, ME, MD, MI, MN, MS, MO, MT, NV, NH, NM, NY, OK, OR, TN, TX, VT, VA, WA. Ten other states have parity bills pending: CT, DE, IL, IA, MA, NJ, NC, OH, PA, RI. Thirteen states have no parity legislative activity: AK, AL, FL, ID, KS, ND, NE, SC, SD, WI, WV, WY, UT. Given the trend, it is reasonable to assume most of the ‘outlier’ states will adopt some form of parity legislation going forward.21

In an attempt to create a national level of consistency as to what constitutes telemedicine or telehealth (the terms are used interchangeably), a bi-partisan bill has been introduced in Congress. H.R. 691, Telehealth Modernization Act of 2015, is co-sponsored by Reps. Doris Matsui (D-CA) and Bill Johnson (R-OH). The bill seeks to break down barriers to the use of telehealth by establishing a federal standard for telehealth and serving as guidance to the states, subject to a number of specified conditions. The bill defines ‘telehealth’ to mean, ‘with respect to health care that a health care professional is authorized to deliver under State law, such health care delivered by such health care professional to such individual not in person, from any location to any other location, and by means of real-time video, secure chat or secure email, or integrated telephony.’ While having this uniform definition across the country is potentially helpful, perhaps
especially as to the reimbursement by payers for telemedicine services on a consistent basis, the bill does not attempt to create any federal standard for licensing providers, meaning the current ‘mosaic’ of state regulation will remain in place, unless states agree to adopt some form of model legislation to facilitate the interstate providing of telemedicine services.

A highly recommended resource is the ‘State Telemedicine Gap Analysis’ for all 50 states and DC, freely available online through the American Telemedicine Association. The analysis reviews in detail key indicators, such as physician practice standards, telepresenter requirements, informed consent, licensure, and prescribing, with individual state report cards and an array of useful matrices and maps.

INSURANCE MARKET TREATMENT OF TELEMEDICINE – PROFESSIONAL LIABILITY

The current consensus across an array of leading Medical Professional Liability (MPL) insurers is that they are flexible in their underwriting approach and not overly concerned regarding telemedicine as an area of risk, recognizing it as an inevitable part of the evolution of health care. A consistent message from MPL insurers is that telemedicine per se is not a ‘professional health care service,’ but rather, a means of delivering professional services with which the insurers overall are generally comfortable and already insuring. From a professional liability standpoint, the MPL insurers are evaluating, on the front end, the risk posed by the health care professionals (primarily physicians, but also ‘physician extenders’) providing health care services as part of the telemedicine enterprise. Essentially the same criteria are used to underwrite the ‘professional’ risk associated with services provided from a ‘distant site’ as are used for services being provided at an established medical site.

That said, some underwriters do express individual concerns regarding the scope of telemedicine for certain medical services and other issues, such as:

- Intraoperative surgical monitoring, regarded as high severity risk by some insurers
- Remote diagnosing, as the principal activity
- Remote prescribing, as the principal activity, especially for controlled narcotics
- Teleradiology – The ‘original’ application of telemedicine, where there is some concern that market pricing has become so competitive, the premiums may be insufficient to support claim frequency
- Applications of telemedicine that might not yet be recognized and accepted by the American Telemedicine Association
- Credentialing of remote providers – A significant concern for some insurers

Also, a consistent theme is concern about the network security and privacy (a/k/a ‘cyber liability’) exposure. Part of the risk evaluation process for most MPL insurers is having an understanding of the technology standards and safeguards being utilized primarily by the remote telemedicine provider, but also by the established medical site, if applicable. Telemedicine providers are well advised to make sure they have robust cyber coverage in place, whether through the same insurer as their MPL coverage or otherwise, owing to the implications for both patient privacy under HIPAA and potential professional liability claims that might be subject to exclusions or sublimits that can prove to be inadequate. Additionally, the prudent telemedicine provider will seek to protect itself contractually or by way of insurance that a third-party technology provider will provide for its errors or omissions.

Further, the onus is clearly on the telemedicine provider to ascertain what licensing might be required for remote location health care providers rendering any form of care to patients in distant states. Most, if not all, MPL insurance policies contain exclusions for ‘illegal’ acts or acts beyond the scope of the license of the health care provider. Thus, the telemedicine entity, with the assistance of legal counsel, must determine for purposes of obtaining insurance that all appropriate licenses are in place. The ‘oops’ factor after a claim occurs will most likely lead to unpleasant consequences.

To this point, major MPL insurers are likewise consistent in having not developed specific coverage forms relating to telemedicine. For the most part, existing MPL (and, where appropriate, GL) coverage forms are used, endorsed as needed to reflect any particular concerns about the exposure.

Finally, this same set of concerns and issues are appropriate to be evaluated by self-funded provider entities utilizing captives, RRGs, or self-funded liability trusts.
TELEMEDICINE LIABILITY

CURRENT CLAIM EXPERIENCE

To date, the incidence of medical malpractice claims involving telemedicine has been low, perhaps due to the facts that there are still many more personal patient-physician encounters than via telemedicine, and liability is still developing. Also, most suits are settled and it is difficult to get a good number due to the lack of reporting in this area. Those claims that we have seen still tend to be in radiology. However, all seem to agree that claims will be on the rise.\textsuperscript{23}

CLAIM AND RISK MANAGEMENT CONSIDERATIONS

Professional liability issues follow closely with the adherence to practice guidelines, state regulations and established law in the various states to shape the standard of practice in this area. In reality, however, much of this is the same standard of care that we have always had; only the mode of transmission is different.

Although there has been very little liability activity concerning telemedicine, one can imagine an array of risks associated with this practice, including:

- Inaccurate diagnosis based on telemedicine information, failure to obtain an adequate medical history
- Technology failure, backup failure
- Remote assessment, relies on patient info or other practitioner to be ‘eyes on’
- Documentation problems
- Lack of Physician-patient relationship
- Credentialing
- Informed consent
- Practicing within telemedicine established protocols, scope of practice protocols
- Incident reporting
- Continuity of care
- Cyber breaches
- Privacy breaches
- Supervision and second look
- Remote monitoring
- Antitrust

SO WHAT CAN WE DO ABOUT THIS?

Finding solutions for anticipated risk before it happens is part of what risk management is all about. Although we do not know exactly what will develop in telemedicine liability, it might look something like this:

<table>
<thead>
<tr>
<th>RISK</th>
<th>POTENTIAL CLAIM</th>
<th>SOLUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inaccurate diagnosis based on telemedicine</td>
<td>Physician did not receive prior documentation of patient’s medical history and diagnosed patient incorrectly</td>
<td>Design protocols and guidelines (ATA, AMA) for history and diagnostic information that must be present prior to consultation via telemedicine</td>
</tr>
<tr>
<td>Remote assessment may rely on another practitioner’s ‘eyes on’ assessment</td>
<td>Physician relied on bedside assessment of nurse to diagnose abdominal tympany and liver palpation for ascites leading to misdiagnosis</td>
<td>Ensure there is adequate skill level of practitioner at patient bedside via credentialing and standards of practice</td>
</tr>
</tbody>
</table>
## RISK POTENTIAL CLAIM SOLUTION

<table>
<thead>
<tr>
<th>Documentation problems/continuity of care</th>
<th>Patient contacts several doctors via different telemedicine systems which do not communicate. Doctor prescribes wrong drug</th>
<th>Consistent electronic medical records accessible to treating practitioners should be part of the telemedicine program; document mode of service, practitioners involved, difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credentialing/scope of practice</td>
<td>Doctor A is covering for Doctor B and has not been oriented correctly to telemedicine protocols and does not follow up with the patient, causing injury</td>
<td>Telemedicine credentialing should include technology orientation, regulation compliance and remote assessment training</td>
</tr>
<tr>
<td>Informed consent/transparency</td>
<td>Online enrollment for telemedicine services does not require patient’s consent for remote consultations causing allegation of lack of informed consent</td>
<td>Patient must consent to telemedicine consultation as well as to any procedures planned</td>
</tr>
<tr>
<td>Technology failure</td>
<td>Physician cannot adequately visualize patient’s wound leading to inadequate treatment and infection</td>
<td>Technology adequate for high level visualization, backup and support should be employed</td>
</tr>
<tr>
<td>Cyber breaches/privacy breaches</td>
<td>Telemedicine system was not secure, leading to hacking personal medical information of patients</td>
<td>Risk management should work closely with administration and IT to ensure security of system; cyber breach insurance may be recommended</td>
</tr>
</tbody>
</table>

## CONCLUSION

Telemedicine is evolving and expanding rapidly on a global basis. Like many technological advances in health care, it offers great promise with respect to cost efficiency, access and quality outcomes. At the same time, telemedicine presents risk challenges to telemedicine operators, remote health care providers and on-site providers, relating to the reliability of the applicable technology, inconsistencies with respect to regulation, patient expectations and insurable risk. Providers contemplating involvement with telemedicine at any level should work with their appropriate professional advisers to carefully evaluate both potential risks and benefits of participating in telemedicine initiatives.
REFERENCES

ATA GUIDELINES FOR PRACTICE 2014

CMS TELE HEALTH SERVICES LIST

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1 Telemedicine Medicaid.gov http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html
3 What is Telemedicine?: www.americantelemed.org
4 www.americantelemed.org/about-telemedicine/what-is-telemedicine
7 AMA Policy H–120.949, Guidance for Physicians on Internet Prescribing
8 AMA Code of Medical Ethics, adopted June 2001
9 AMA Policy H–120.949, Guidance for Physicians on Internet Prescribing
11 www.ama-assn.org/ama/pub-resources/legal-topics/telemedicine.page
12 Cal. Bus and Prof Code Sec. 2290.5(b)
13 Fla. Admin. Code R.64B8-9.014
15 H.R.S. Secs. 453-1.3(d) and 453-1.3
16 22 TX A.D.C. Sec. 174.2
17 22 TX A.D.C. Sec. 174.2
18 22 TX A.D.C. Sec. 174.6
19 22 TX A.D.C. Sec. 174.7
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