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CLIENT ADVISORY

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Virginia General Assembly Paves Way for Expanded Telemedicine Consultations and Prescribing

On March 16, 2015, Virginia Governor Terry McAuliffe signed HB 2063,[1] which amends the definition of "telemedicine services" to more broadly permit remote patient diagnosis and prescription of Schedule VI medications as defined by the Virginia Drug Control Act. The new Virginia law takes effect on July 1, 2015. Under the old law, Va. Code § 54.1-3303 required providers to form a "bona fide practitioner-patient relationship" by conducting an "appropriate examination" before prescribing medication. Uncertainty regarding what made an examination legally "appropriate" fostered considerable confusion among telemedicine providers. The new law addresses this ambiguity by unequivocally permitting the formation of a practitioner-patient relationship and subsequent prescribing via telemedicine when certain conditions are met.

What Type of Telemedicine is at Issue?

While "telemedicine" is a broad concept, this legislation addresses just one of its applications - prescribing via remote patient consultation. Many telemedicine activities, including remote radiology reviews, electronic record transfers, and physician-ordered electronic consultations are not affected by this law.

This legislation primarily impacts remote diagnosis and treatment of minor conditions such as sore throat or influenza by a physician who is not the patient's primary care provider and with whom the patient does not have a pre-existing physician-patient relationship. Patients generally utilize these telemedicine consultations as a convenience service offered by their health insurance company or employer. Prior to the consultation, patients log on to a provider's web site, enter demographic and medical history information, provide pertinent medical records, and describe the nature of their symptoms. An online system then connects the patient with a state-licensed physician either by phone or two-way videoconferencing technology for an evaluation and discussion about the complaint. More advanced versions of these consultations may involve use of peripheral applications like picture forwarding or computer-connectible electronic devices such as electronic stethoscopes or thermometers. The physician then diagnoses the patient and prescribes appropriate medication. Records of the encounter may be forwarded to the patient's primary care provider or to the patient herself.

How the Virginia Law Works

The primary focus of this legislation is to permit physicians who evaluate patients via "telemedicine services" to prescribe Schedule VI medications. It does this by expanding the manner in which a physician-patient relationship may be formed. Specifically, the new law provides that for the purpose of prescribing a Schedule VI medication, a bona fide practitioner-patient relationship may be established not only through a traditional physical examination, but also by examination utilizing one of two electronic methods: 1) face-to-face, two-way real-time communications services, or 2) store-and-forward technology. The first category provides for the use of HIPAA-compliant videoconferencing technology that facilitates a face-to-face conversation and evaluation between provider and patient. This consultation format may also involve more advanced types of interactive peripheral devices which can remotely assess vital statistics or transfer real-time data. The second category - store-and-forward technology - collects information such as medical history or medical records from patients. When a patient initiates a telemedicine consultation and submits his symptoms and complaints, all of the information is forwarded

[1] The Governor also signed an identical Senate bill – SB 1227 – on February 26, 2015.

electronically to a physician who then reviews it and calls the patient to discuss the issue. This legislation does not permit telephone-only or email-only consultations, and it continues the pre-existing ban on prescribing based on internet questionnaires.

In both video communication and store-and-forward scenarios, the physician-patient relationship can only be formed (and prescribing allowed) if the following additional conditions are met:

1) The patient provides a medical history which is made available for review by the prescriber;

2) The prescriber obtains an updated medical history at the time of prescribing;

3) The prescriber makes a diagnosis at the time of prescribing;

4) The prescriber conforms to the standard of care expected of in-person traditional exams, including the use of diagnostic testing or physical examination via condition-appropriate peripheral devices;

5) The prescriber is licensed in Virginia and authorized to prescribe;

6) If the patient is enrolled in a health care plan, the prescriber is credentialed by the health plan as a participating provider and the prescribing meets the plan's qualifications for reimbursement; and

7) Upon request, the prescriber provides medical records from the consultation to patients or their primary care physicians in a timely manner.

These conditions put baseline parameters on telemedicine consultations and ensure that certain basic safeguards are present every time medication is prescribed telemedically. If the telemedicine consultation fails either to utilize one of the two approved methods or meet the conditions set forth in the legislation, a physician-patient relationship is not formed and prescribing is not permitted.

Additional Safeguards & Scope Limitations

In addition to the safety considerations articulated in the conditions listed above, the legislation features built-in safeguards which narrow its scope.

Most significantly, this law applies only to prescription of Virginia Schedule VI controlled substances. All other drug classifications still require prescription preceded by traditional in-person physical examination. If a patient presents with a condition requiring more aggressive treatment than Schedule VI medications can provide, the patient must seek an in-person evaluation by a licensed practitioner. The natural consequence of this limitation is that telemedicine services will only be a viable treatment option for low-acuity conditions. This is already the model for most telemedicine service providers and this law ensures that it will not expand into more serious diagnostic territory without additional technological advancements and reconsideration by the General Assembly. Notably, this legislation does not prohibit on-call prescribing of Schedule I – V medications where the treatment is part of a pre-existing physician-patient relationship.

The law additionally makes clear that the standard of care established for physicians providing in-person care fully applies to telemedicine practitioners as well. The standard of care does not differ merely because the care is provided electronically; telemedicine does not have its own standard of care. In some cases this may create an obligation to refer the patient for in-person evaluation or further physical testing. Where diagnosis of a patient during an in-person examination requires blood work, for example, telemedicine practitioners cannot sidestep that requirement. The new law is unequivocal: "[A] prescriber [cannot] 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."

Looking Ahead

For proponents of telemedicine, this new law may support future legislative steps to facilitate increased use of remote medical technology. For those wary of an overly aggressive expansion, the law provides substantive safeguards that meaningfully restrict prescribing to the lowest-classification drugs for the lowest-acuity diagnoses within the framework of the existing standard of care. Robin Cummings, Director of Health Policy and Research at the Medical Society of Virginia, acknowledged the careful balance the law achieves: "This new law encourages emerging technology to provide additional diagnostic tools to practitioners and expanded access to patients while simultaneously establishing meaningful safeguards that preserve a high standard of care."

In anticipation of this legislation's passage, on February 19, 2015 the Virginia Board of Medicine released its long-awaited Guidance Document on Telemedicine.[2] Although that document restates the safety principles included in the new law and reiterates the importance of the standard of care, it does not shed significant light on how the Board will adjudicate particular telemedicine cases going forward. But future enforcement will only be triggered by individual complaints. The analysis in these cases will no longer be whether the telemedicine format is appropriate, but whether the diagnosis and treatment complied with the standard of care. Proving that will depend on thorough and thoughtful documentation at every stage of the telemedicine consultation. The Board is expected to update its guidance now that the Governor has signed the legislation.

If you have any questions related to this new law or telemedicine practice generally, please contact Jerry Canaan (jcanaan@hdjn.com) or Scott Johnson (sjohnson@hdjn.com). They can be reached by phone at 804-967-9604. Additional information about Hancock, Daniel, Johnson & Nagle, P.C. is available on the firm's website at www.hdjn.com.

[2] Guidance Document 85-12. This Guidance Document does not have the force of law; it is merely guidance from the Board of Medicine to health care practitioners to aid their understanding of existing law.