While Rules Evolve Telemedicine is Alive and Well in Texas

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The eyes of the nation are focused on Texas, this time in relation to telemedicine—healthcare services that use the telephone, Internet and mobile technology to offer patients prompt, real-time access to medical professionals located elsewhere. Since 2010, the Texas Medical Board has adopted a series of amendments to its rules at Chapter 174 of the Texas Administrative Code, relating to telemedicine, and §190.8(1)(L) of the Texas Administrative Code, relating to prescriptions.

Certain of these amendments have sparked controversy, including a widely publicized dispute between the board and Teladoc, a direct-to-consumer healthcare company, that is winding its way through Texas state and federal courts. Published reports have highlighted concerns that the board's actions will "drive a stake in the heart" of telemedicine in Texas, that Texas is "moving in the opposite direction" from the national trend toward loosening restrictions on telemedicine, according to an April 10 article in The New York Times, and that Texas has "[shot] itself in the foot with new telemedicine restrictions," according to an April 20 story in MedCity News.

Despite such dire proclamations, many telemedicine models are alive, well and permissible in Texas, even as we await the outcome of the Teladoc litigation, which primarily affects services offered by telephone directly to consumers by physicians with whom there is no existing patient relationship.

As explained by the board, a physician is using telemedicine to practice in Texas, and thus subject to the telemedicine rule, if the physician, while physically located at a "distant" site (not where the patient is), provides medical evaluation, diagnosis, consultation or treatment that requires technology allowing the physician and patient to see and hear one another in real time. Telemedicine may involve consumer applications such as Skype or FaceTime, or advanced medical communications technology such as that used by hospitals with radiologists, neurologists, and intensivists. The telemedicine rule imposes certain compliance obligations unique to the practice of telemedicine, including technology and security requirements, fraud and abuse prevention measures, and the implementation of protocols relating to patient notices and disclosures.

A particularly nuanced element of the telemedicine rule provides that, unless the patient has been referred by another physician who has conducted a documented in-person examination, the distant physician must establish a proper professional relationship with the patient. In some states, that requires an in-person examination (e.g., Arkansas Code § 17-80-117(e)); in others, it can be done "virtually" using video conferencing (e.g., Florida Administrative Code 64B8-9.0141(8)). In Texas, it can be done either way, but if done by video conferencing the patient must be at an "established medical site."

The "established medical site" requirement includes two key factors, which together replicate virtually an in-office exam for patients seeing a physician for the first time. First, the location must have a "presenter" who is available to take direction from the distant physician and physically interact with the patient, though the telemedicine rule does not require a presenter for the delivery of most mental health services. The presenter must be a Texas-licensed or certified healthcare professional, such as a physician assistant, nurse, pharmacist or emergency medical technician.

Second, there must be on-site technology sufficient to enable the remote physician to gather data and conduct an evaluation consistent with in-person requirements, guided by the condition and circumstances of the patient. If the presenter and technology factors are satisfied, telemedicine can be used wherever a patient seeks medical care, including a hospital, clinic, pharmacy, infirmary, nurse's office, school, retail location, or even a patient's home. Using telemedicine, a community that lacks primary or specialized care can access that expertise remotely; a rural hospital or clinic can link with a tertiary care facility for specialized evaluation, consultation and treatment; a school nurse's office or infirmary can access remote physicians and resources; and a company clinic or nurse's office, even one set up at a remote work-site, can access medical services using advanced technology.

After the physician has established the professional relationship and made a diagnosis, whether by telemedicine or otherwise, the physician and patient might communicate about the patient's health condition in any number of ways, including traditional in-person visits as well as by telephone, text, email or video conference. The physician may decide whether to use a presenter during future telemedicine encounters relating to the same diagnosis, and the telemedicine rule offers flexibility in relation to new conditions in established patients.

To date, the telemedicine rule has changed little as it relates to consultations among licensed providers or referrals by physicians who have already evaluated the patient. Accordingly, the telemedicine rule and the prescribing rule, even as recently revised, should not interfere with historical or emerging provider-to-provider models, such as teleradiology, teleneurology or specialist consultations. Although some concerns have been raised about the scope of on-call coverage under the telemedicine rules, the board at its August 2015 meeting instructed its staff to draft revised language facilitating on-call specialty services. Those changes would likely take effect in 2016.

Remote direct-to-consumer models struggle with the telemedicine rule because those providers do not typically establish a physician-patient relationship in-person or using video conferencing at an established medical site as contemplated by the telemedicine rule. And without establishing a professional relationship in accordance with the telemedicine rule, the distant physician cannot write a prescription for the patient under the recently modified, but since enjoined, prescription rule. Teladoc is challenging the board's recent action regarding the prescription rule in both Texas state court (on administrative law grounds) and Texas

federal court (on antitrust grounds), and has won temporary injunctions of recently amended portions of the prescription rule in both venues. Both threads of litigation remain ongoing.

Although Texas is in the spotlight, it is not alone in grappling with how to regulate telemedicine. State medical boards across the nation are working to balance the sometimes conflicting interests of patients seeking convenient, inexpensive access to medical care; private insurance companies, governmental programs and employers working to reduce costs and increase efficiencies; entrepreneurial providers using advanced technology and remote access models to offer on-demand services; and public health and safety within the context of the physician-patient relationship. While Texas may be taking a different path than other states, telemedicine remains alive and well in Texas.

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