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FROM THE CALIFORNIA PHYSICIAN'S LEGAL HANDBOOK

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Telehealth

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The use of technology is an integral part of the provision of health care and physicians are embracing the use of telemedicine and telehealth in their practices. Telehealth has the potential to improve access to care, reduce costs and facilitate physician communication with their patients. The rapidly evolving technology, however, also raises issues related to reimbursement, appropriate uses of telehealth and telemedicine, patient consent, security and confidentiality. The following document discusses telemedicine generally and the major issues physicians face when employing telemedicine or telehealth in their practice.¹

TELEMEDICINE AND TELEHEALTH DEFINED

The most important question in telemedicine law is “*What is telemedicine?*” Finding the answer to this question is often a daunting task, for one, because there are so many different codified words with overlapping meanings, including such words as telehealth, connected health, digital health, practice via electronic means, remote practice, etc. The definition will also vary depending on why you are asking the question. There are three main reasons that someone would need to know the definition of telemedicine or telehealth for a particular patient encounter: 1) practice requirements for telehealth; 2) reimbursement; and 3) the proper patient–physician relationship.

Defining what constitutes telemedicine or telehealth becomes important in determining whether a patient encounter triggers specified state practice restrictions that are applicable solely because the healthcare

encounter was facilitated via technology instead of via a traditional in-person encounter between the patient and physician.

The California statute that addresses telehealth practice standards is Business & Professions Code §2290.5. As defined in the law, telehealth is: “the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.”

This definition of telehealth from §2290.5 is incorporated by reference throughout California codes, as discussed in more detail in the sections below.

1. This ON-CALL document was authored and updated in part by Tara Kepler, J.D., M.P.A. at Bryan Cave, LLP, an attorney specializing in telemedicine and digital health law.

CMA PRINCIPLES OF TELEMEDICINE

In 2015, CMA's Board of Trustees adopted the *Principles of Telemedicine* that states:

1. **General Support.** CMA supports the use of telemedicine as an avenue to ensure quality and improve access to care.
2. **Physician–Patient Relationship.** Physicians should engage in the medical advice and/or care using telemedicine technologies under the following circumstances:
 - ♦ A physician–patient relationship must be established, through at minimum, a face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine. The face-to-face encounter could occur in person or virtually through real time audio and video technology.
 - ♦ Obtaining appropriate consent from requesting patients after disclosures regarding the delivery models and treatment methods or limitations.
 - ♦ Establishing the identity of the physician to the patient.
 - ♦ Where possible, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.
 - ♦ Patients should be able to seek, with relative ease, follow-up care information from the physician (or physician's designee) who conducts an encounter using telemedicine.
3. **Interstate Licensure.** CMA will not support any interstate medical licensure compact that would allow physicians to circumvent the proper channels for obtaining a license in California for purposes of the delivery of medical services, including the provision of medical services through the use of telemedicine technologies. In addition:
 - ♦ The use of telemedicine technologies must be in accordance with California laws regulating scope of practice.
 - ♦ A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located.

4. **Reimbursement.** Patient care services of similar complexity and requiring similar physician resources, shall be reimbursed equally regardless of whether the service is delivered in-person or via telemedicine.

(BOT 2015-07-24:3; Amended BOT 206-16.)

TELEHEALTH STANDARDS

Many states impose additional restrictions or requirements when a health care interaction involves telemedicine. California significantly reduced those additional barriers to telemedicine when the Legislature passed A.B. 415 in 2011 and A.B. 809 in 2014. Prior to the passage of A.B. 415, health care practitioners were subject to onerous, additional informed consent and medical record documentation standards solely because a health care service was provided via remote technology modalities. With the amendments to Business & Professions Code §2290.5 in A.B. 415 and A.B. 809, these heightened requirements were eliminated, and a telemedicine encounter is now subject to the same medical record documentation, consent, and privacy standards that apply to all other health care encounters.

Consent

Effective September 18, 2014, the consent standard is simply that: “the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.” The law specifically states that it does not preclude a patient from receiving care in-person if they choose even after agreeing to receive services via telehealth. (Business & Professions Code §2290.5; A.B. 809, Stats. 2014, ch. 404.)

However, it is important to note that California has created a heightened consent standard as a condition for Medi-Cal reimbursement for psychiatric diagnostic interview examination and selected psychiatric therapeutic services when performed via telemedicine. *See* the Medi-Cal reimbursement section herein for further details. *See Medi-Cal Provider Manual: Telehealth*, Department of Health Care Services (DHCS) website at www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx.

Medical Record Documentation

In addition to documenting consent, California law also expressly requires practitioners to fully document and memorialize all other details of a telehealth interaction in the patient's medical record, as the practitioner would for any other type of health care interaction with the patient. (Health & Safety Code §123149.5(a).) Physicians should also be aware of the application of this medical record documentation requirement when collaborating with other health care practitioners, entities or facilities on telehealth ventures because the law applies to almost any health care entity, facility or person who has "responsibility for decisions respecting the health care of others." (Health & Safety Code §§123100, 123105.)

Licensing Laws of Other States

California physicians seeking to provide telehealth services to patients located outside California should be aware that such actions will implicate any heightened medical licensing laws and additional requirements of the state in which the patient is located. *See, e.g., Holzhauser v. State Med. Bd. of Ohio* (Ohio Ct. App. Sep 25, 2007) No. 06AP-1031, 2007 WL 2773472, at *3. Thus, even if a telehealth practicing physician is able to take advantage of an out-of-state licensing exception to provide health care services via telehealth (such as the common consultation exceptions applicable in many states) such licensing exception does not exempt the physician from being aware of and complying with any heightened telehealth practice requirements unique to a specific state.

Led by the Federation of State Medical Boards (FSMB), there are currently efforts underway to implement an interstate licensing compact to facilitate the practice of medicine across state lines. In November 2014, the American Medical Association (AMA) adopted policy supporting the FSMB Interstate Compact for Medical Licensure and the creation of the Interstate Medical Licensure Compact Commission to encourage increased standardization of credentials requirements and reciprocity between licensing jurisdictions. (AMA Policy D-275.994 (2014).) As of January 2019, 25 states have passed legislation and seven states have active legislative bills to adopt the FSMB's Interstate Medical Licensure Compact. In addition to CMA's 2015 Principles of Telemedicine regarding interstate licensure as discussed

above, CMA policy supports the use of telehealth technologies, such services must be provided by physicians and other health care practitioners that are properly licensed in the state of California. (HOD 608-14.) For more information on the FSMB's Interstate Medical Licensure Compact, visit www.imlcc.org/.

Aiding and Abetting the Unlicensed Practice of Medicine

Aiding and abetting the unlicensed practice of medicine is a common risk for telehealth ventures involving any corporate entities or persons without sufficient medical licensing credentials for the given telehealth interaction—including sufficient licensing credentials under any implicated laws of other states. California, like most other states, expressly subjects anyone, not just licensed physicians, to criminal sanctions for aiding and abetting the unlicensed practice of medicine. (Business & Professions Code §§2052, 2264; *see also Steinsmith v. Medical Board* (2000) 85 Cal.App.4th 458 (prohibition against the corporate practice of medicine).) This is particularly relevant to California-based ventures because California has been the first state to successfully pursue criminal prosecution for the unlicensed practice of medicine via telehealth. *See the Hageseth* discussion in the section below entitled "Prescribing and Dispensing Via Telehealth."

Further, a California state appellate court held that two non-physician owners of a facility in California were criminally liable for the unlicensed practice of medicine because they owned and operated the facility as a medical clinic. (*People v. Superior Court (Cardillo)* (2013) 218 Cal.App.4th 492.) Specifically, the court held that the owners were participating in the unlicensed practice of medicine because they controlled the operations of the clinic, contracted with licensed physicians to issue recommendations for prescription medications, set the physicians' hours, solicited and scheduled patients, collected fees from the patients, and paid the physicians a percentage of those fees. The court also held that the owners were not absolved of criminal liability for practicing medicine without a license simply because they did not actually examine any patients or prescribe any medications.

This legal dilemma is particularly relevant to the telehealth niche of the healthcare industry because successful telehealth ventures usually involve entities outside the health care industry such as technology experts and venture capitalists. Properly compensating these entities for their role in a telehealth project may violate laws related to the unlicensed practice of medicine and the corporate bar on the practice of medicine.

This is the core question to address upfront because the distinction between what is and is not the practice of medicine by a person (or corporation) is not clearly defined and is the subject of recurring litigation. *See, e.g., Conrad v. Medical Bd.* (1996) 48 Cal.App.4th 1038 (The doctrine is intended to ameliorate the evils of divided loyalty and impaired confidence which are thought to be created when a corporation solicits medical business from the general public and turns it over to a special group of doctors, who are thus under lay control.) For more information on the bar on the corporate practice of medicine, *see* [CMA ON-CALL document #0200, "Corporate Practice of Medicine Bar."](#)

Most states, including California, prohibit physicians from "splitting" their fees with non-physicians and from participating in illegal patient referral kickback schemes. *See, e.g.,* Business & Professions Code §§650, 652 (defining illegal fee-splitting with physicians and assigning criminal penalties). The distinction between illegal fee splitting and legitimate payments for non-medical services is not yet well defined for novel telehealth ventures. This is a rapidly evolving area of the law, and the division of funds generated by the telehealth venture can easily transform into criminal fee splitting if not properly structured and managed. *See, e.g.,* 55 Ops. Cal. Atty. Gen. 103 (1972) ("There is nothing whatsoever in such an arrangement which would indicate the portion of fees received by the [entity] would be commensurate with its own expenses incurred in connection with the furnishing of diagnostic facilities. On the contrary, the [entity's] receipts are directly proportionate to the physician's profit factor, bearing no necessary relationship to its expenses. Such a plan constitutes in effect a partnership or joint venture and plainly violates the proscription against unearned rebates.")

The variety in state laws and enforcement on these issues requires multi-state telehealth project managers

to consider a variety of initial questions when deciding how best to structure the arrangement. For example, if a patient pays for an online consultation by a physician, who is permitted to take a piece of that payment and under what terms? When does a telehealth website become a referral source for a physician? Are there payments between the technology company and the physician-owned company that qualify as illegal kickbacks for generating healthcare business? An initial issue for those pursuing a telehealth business idea is to decide exactly how the relevant players will be able to affiliate with one another and distribute profits in a compliant manner. Other questions related to this decision are: 1) will the payments generated by the telehealth venture be made to a physician-owned entity or to some other entity; 2) is the use of a novel diagnostic software tool the practice of medicine; and 3) are non-physicians profiting from physician services.

Physicians should consult with experienced legal counsel and ensure that they are familiar with all relevant state authorities on fee splitting for telehealth ventures as some states rely heavily on their corporate practice of medicine authorities for this (located in statutes, regulations, case law and even attorney general opinions) rather than conveniently referring to it simply as "health care fraud" or "illegal kickbacks for referrals".

[No Special Telehealth Registration or Permit](#)

Some states have a special registration or permitting requirement for in-state and/or out-of-state physicians seeking to treat patients via telehealth but California does not yet have either of these requirements. The California medical licensing law is broad enough to include telehealth-specific activities, so a regular California license to practice medicine is currently all that is required for providing care to California patients via telehealth. *See* Business & Professions Code §2052.

Of note, California is often incorrectly listed among the states requiring a special telehealth permit due to a California statute that appeared to, but ultimately did not, require such. *See* Business & Professions Code §2052.5. As discussed previously on the Medical Board website:

California has no telemedicine registration program. In 1996, the Board sought legislation to obtain the regulatory authority to develop a

program for physicians in other states to become registered in California, without requiring full licensure. The legislation was unsuccessful in obtaining regulatory authority, and, instead, added §2052.5 of the Business & Professions Code. This code has been the source of some confusion, as it outlines the original proposal for the registration program, but requires the Board to seek legislation to place a future program in statute. Those unfamiliar with the law's history assume that the Board has a program or the authority to implement one—the Board has neither.

(*Practicing Medicine Through Telemedicine Technology* no longer available on the Medical Board of California website at www.mbc.ca.gov/Licensees/Telehealth.aspx.)

Different Standards of Care and Malpractice Risks

While California statutes do not expressly create different standards of care for health care services provided via telehealth, physicians should be aware of the unique standard of care issues that telehealth activities could present, depending on the nature of services being provided via telehealth. For example, below are examples of a few heightened standards of care guidelines developed by professional organizations that are specific to the unique risks presented by the use of telehealth:

- Society of American Gastrointestinal and Endoscopic Surgeons' Guidelines for the Surgical Practice of Telemedicine (available at <https://www.sages.org/wp-content/uploads/wp-post-to-pdf-enhanced-cache/1/guidelines-for-the-surgical-practice-of-telemedicine.pdf>);
- American Academy of Dermatology Association's Position Statement on Telemedicine (available at www.aad.org/Forms/Policies/Uploads/PS/PS-Telemedicine%206-15-07.pdf); and
- American Psychological Association's Statement on Services by Telephone, Teleconferencing, and Internet (available at www.apa.org/ethics/education/telephone-statement.aspx).

Also, there might be exceptions to traditional standards of care if telehealth is involved when there is inadequate access to healthcare professionals for an "in-person" interaction. For example, a New Jersey

appellate court reviewed a state agency's decision to waive the in-person requirement for involuntary commitment assessments through telepsychiatry due to a lack of available psychiatrists. (*In re Div. of Mental Health Servs.* (N.J. Super. Ct., App. Div. Jun. 17, 2009) No. A-2966-07T2, 2009 WL 1675502, *3–7 (*per curiam*).) Though the waiver argument was ultimately unsuccessful for other reasons, the court discussed that psychiatry assessments through remote means in which the psychiatrist interviews the patient through video technologies can often be done in accordance with established standards of care. Thus, it may be reasonable to waive the in-person requirement in rural areas or at odd hours of the night in emergency situations in which a specialized healthcare professional is not easily available to make the required in-person assessment.

The virtual nature of a telehealth encounter also automatically creates novel malpractice and liability risks related to the following questions:

- Whether all practitioners have ultimate or shared authority over the care of the patient?
- Who all has created a physician–patient relationship through the activity?
- Are there any lingering patient abandonment or continuity of care issues once the telehealth interaction is over?
- Have all involved parties been properly trained on the use and capabilities of the telehealth technologies and software being used?
- Is the activity expressly or implicitly excluded from malpractice coverage because it is accomplished via telehealth?

Physicians should contact their professional liability carrier for information regarding their coverage and liability for telehealth encounters.

REIMBURSEMENT

Physician services are reimbursable for a telemedicine encounter if the encounter fits the definition of a reimbursable telemedicine service as defined under all relevant laws or contractual provisions. For example, if the encounter is with a California patient who is covered by private health insurance, then the definition will be dictated, in part, by California's telehealth health care insurance non-discrimination

statute, individual health plan contracts, provider manuals, and evidences of coverage that the health plan has with the physician and patient in question.

In contrast, the definition of reimbursable telemedicine services for other telehealth encounters in which the patient is covered by Medicare or Medi-Cal will be derived from completely different sets of laws and contractual provisions.

The analysis, however, does not end there for reimbursement. In addition to each of these varied sets of payor-specific laws defining telemedicine and telehealth, claims for reimbursement from both private and public payors require, as a condition for reimbursement, that the service was provided in compliance with state laws. Thus, even if the reimbursement requirements for telemedicine are met, the physicians must also assess whether a proper patient–physician relationship can be established via technology used for the encounter under the Medical Practice Act.

Private Pay

Under California law, health insurers and managed care plans are prohibited from excluding coverage for a telehealth service solely because the service did not involve an in-person encounter between the patient and the provider. (Insurance Code §10123.85; Health & Safety Code §1374.13.)

These types of laws are common across the United States and are often classified as telehealth “non-discrimination” statutes. However, these statutes often have little teeth to them because the more common and cost-effective types of telehealth encounters—those via email or telephone—are usually expressly excluded from the definition of telehealth in this context. Such has been the case in California for the past decade. This changed on January 1, 2012, when the new A.B. 415 became effective. The new A.B. 415 definition of telemedicine (now referred to as “telehealth”) no longer expressly excludes email and telephone communications. Thus, these California telehealth non-discrimination statutes for private health insurance and managed care payors could create a new demand for reimbursement and coverage for these types of telehealth encounters that have been largely dismissed as non-reimbursable, non-covered patient encounters over the years.

Reimbursement and coverage for these encounters, though, will still be dictated by the individual health plan contracts, provider manuals and evidences of coverage that payors have with providers and plan members. However, any coverage rules that discriminate against coverage solely because the service was provided via a remote technology modality is likely void and unenforceable as of January 1, 2012. Ultimately, this coverage battle will likely result in disputes and appeals over the medical necessity or appropriateness of a given service being provided remotely, as compared to the provisions of the same service in a face-to face, traditional encounter.

Payors, providers and health care regulators would be wise to begin collaboratively defining the types of services that are more or less likely to be appropriately provided via remote technology and begin creating an industry-wide consensus on this pervasive question. Regardless, any provider seeking to reap the possible coverage benefits of A.B. 415 should be sure to research and document why it is medically appropriate in a given scenario to provide a health care service via telephone, email or any other remote technology modality. Of note, managed care plans under the authority of the California Department of Managed Health Care (DMHC) are allowed to meet their “accessibility of services” requirements via telehealth modalities and telehealth service providers. (Health & Safety Code §1374.13; 28 C.C.R. §1300.67.2.) CMA continues to work legislatively to require wider reimbursement coverage for telehealth services.

Medicare

The general rule for Medicare reimbursement for a health care service is that there must be “face-to-face contact” between the patient and provider. However, the Centers for Medicare and Medicaid Services (CMS) has carved out a limited exception to this rule for certain Medicare Part B telehealth encounters in which telehealth is essentially the only option for delivery of the health care service because an in-person encounter is not otherwise feasible. (42 U.S.C. §1395m(m); 42 C.F.R. §§410.78, 414.65; *Medicare Claims Processing Manual*, ch. 12, §190.)

More specifically, Medicare only covers telehealth services when each of the following required elements are met: 1) the Medicare beneficiary received the

telehealth service at an acceptable “originating site”; 2) an approved telehealth modality was used; 3) an approved service and billing code was used; and 4) the telehealth service was provided by an approved health care provider at the “distant site.”

Below is a summary of the current terms of these required elements, but they are subject to regulatory and statutory changes from year to year. Thus, providers should check the most recent version of the relevant Medicare reimbursement manual provisions to verify coverage terms. See *Medicare Claims Processing Manual*, ch. 12, §190, available on the CMS website at www.cms.gov/manuals/downloads/clm104c12.pdf.

Approved Originating Site

Under most circumstances, an originating site must be located in a rural health professions shortage area (HPSA) or outside a Metropolitan Statistical Area (MSA). The originating site must also be one of the following to qualify:

- Physician or practitioner office;
- Inpatient or outpatient hospital;
- Critical access hospital (CAH);
- Rural health clinic (RHC);
- Federally qualified health center (FQHC);
- Renal dialysis center;
- Skilled nursing facility; or
- Community mental health center.

Medicare also requires a “telepresenter” to be physically present with the Medicare beneficiary at the originating site, but only if it is medically necessary for the telehealth service, as determined by the distant-site physician. (*Medicare Claims Processing Manual*.) Thus, Medicare does not have a blanket telepresenter requirement for telehealth reimbursement.

Approved Telehealth Modalities

Medicare only reimburses telehealth services provided in live, real-time situations in which the physician is interacting with the Medicare beneficiary via an interactive telecommunications system (except for certain telehealth demonstration projects in Hawai‘i and Alaska). Medicare does not reimburse for telehealth services provided via telephone, email, or fax.

Approved Services and Billing Codes

The following are the current Medicare-reimbursable telehealth services, but the list is re-evaluated annually:

- Telehealth consultations, emergency department or initial inpatient (HCPCS codes G0425–G0427);
- Follow-up inpatient telehealth consultations (HCPCS codes G0406, G0407, and G0408);
- Office or other outpatient visits (CPT codes 99201–99215 and 99354–99355);
- Subsequent hospital care services, with the limitation of one telehealth visit every three days (CPT codes 99231, 99232, 99233, 99356, and 99357);
- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days (CPT codes 99307, 99308, 99309, and 99310);
- Pharmacologic management (HCPCS code G0459);
- Individual psychotherapy (CPT codes 90832–90834, 90836–90840);
- Psychiatric diagnostic interview examination (CPT codes 90785, 90791–90792);
- Neurobehavioral status exam (CPT code 96116);
- End Stage Renal Disease (ESRD) related services (CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963–90970);
- Individual and group medical nutrition therapy (HCPCS codes G0270, 97802, 97803, and 97804);
- Individual and group health, behavior and risk assessment and intervention (CPT codes 96150–96154, 96160–96161);
- Individual and group kidney disease education (KDE) services (HCPCS codes G0420 and G0421);
- Individual and group diabetes self-management training (DSMT) services, with a minimum of one hour of in-person instruction to be furnished in the initial year training period if injection training is applicable (HCPCS codes G0108 and G0109);
- Smoking Cessation Services (CPT code 99406);

- Counseling for lung cancer screening need (HCPCS code G0296)
- Tobacco use counseling (HCPCS codes G0436, G0437)
- Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services (HCPCS codes G0396 and G0397);
- Annual alcohol misuse screening (HCPCS code G0442);
- Brief face-to-face behavioral counseling for alcohol misuse (HCPCS code G0443);
- Annual Depression Screening (HCPCS code G0444);
- High-intensity behavioral counseling to prevent sexually transmitted infections (HCPCS code G0445);
- Annual, face-to-face Intensive behavioral therapy for cardiovascular disease (HCPCS code G0446);
- Telehealth consultations for critical care (HCPCS codes G0506, G0508–G0509);
- Face-to-face behavioral counseling for obesity (HCPCS code G0447); and
- Transitional Care Management Services (CPT codes 99495–99498).

(Medicare Claims Processing Manual.)

Medicare payment to the distant site practitioner for a telehealth service is the same amount that Medicare would have paid under Part B if the service had not been provided via telehealth. Distant site practitioners must submit the appropriate procedure code for covered professional telehealth services along with the new place of service code “02 Telehealth: The location where health services and health related services are provided or received, through a telecommunication system”. Practitioners must also submit the procedure code with the “GT” modifier (“via interactive audio and video telecommunications system”). By coding and billing the “GT” modifier with a covered telehealth procedure code, the distant site practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished.

In addition to the reimbursement of the physician at the distant site, qualifying originating sites may also bill Medicare for a facility fee related to the provision of the telehealth service with HCPCS code Q3014 as the “telehealth originating site facility fee.”

Approved Health Care Provider at Distant Site

The physician or practitioner at the distant site must be licensed under state law to provide the telehealth service and must be one of the following types of practitioners:

- Physician;
- Nurse practitioner;
- Physician assistant;
- Nurse-midwife;
- Certified Registered Nurse Anesthetist;
- Clinical nurse specialist;
- Clinical psychologist;
- Clinical social worker; or
- Registered dietitian or nutrition professional.

(Medicare Claims Processing Manual.) Note that clinical psychologists and clinical social workers are not authorized to bill for psychotherapy services that include medical evaluation and management services under Medicare and are not authorized to bill for the following CPT codes: 90805, 90807, and 90809.

Medi-Cal

State Medicaid programs are not bound by the Medicare rules for reimbursable telehealth services, and the California Legislature has given the Department of Health Care Service (DHCS) broad discretion in defining what telehealth services may be covered under the California Medicaid program (“Medi-Cal”). See Welfare & Institutions Code §§14132.72, 14132.725, 14132.73.

The DHCS’s Medi-Cal Provider Manual details the requirements and covered services for health care services provided via telehealth to Medi-Cal beneficiaries. While DHCS has adopted many of the Medicare telehealth reimbursement principles, Medi-Cal telehealth coverage is fundamentally different from Medicare. With the passage of A.B. 415, the California Legislature gave DHCS even more latitude in coverage for telehealth services. See *Medi-Cal Provider Manual: Telehealth*. DHCS is in the process of revising its telehealth policy to significantly broaden its telehealth coverage, provide more flexibility in using telehealth, including e-consults. Physicians should look for updates on the DHCS website at www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx.

For the time being, as summarized in more detail below, Medi-Cal essentially covers three categories of telehealth services: 1) real-time psychiatric and psychotherapy services; 2) real-time evaluation and management (E&M) services; and 3) select, asynchronous ophthalmology and dermatology E&M services. In addition, Medi-Cal pays for transmission costs (up to 90 minutes per patient, per day, per provider), the originating site facility fee, and interpretation and report of x-rays and electrocardiograms performed via telehealth.

While a patient's written consent to telehealth services is no longer required, prior to a patient receiving services via telehealth, the health care provider must inform the patient of the option to use a telehealth modality and obtain oral or written consent from the patient for the use of telehealth and retain documentation confirming that the consent was obtained. (Business & Professions Code §2290.5.)

Real-Time, Interactive Psychiatric and Psychotherapy Services

Similar to Medicare, Medi-Cal covers psychiatric and psychotherapy services when provided via telehealth during a real-time interaction with the patient at an approved originating and distant site. The following psychiatric and psychotherapy services are reimbursable when performed according to telemedicine guidelines and billed with modifier GT (service rendered via interactive audio and telecommunications systems) or 95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system) and the appropriate CPT-4 or HCPCS code: 90791, 90792, 90863, 90832, 90837, G0508, and G0509.

Medi-Cal requires that the patient orally consent and the physician document the oral consent in the patient's medical record to each of the following prior to the commencement of a Medi-Cal reimbursable telemedicine encounter for psychiatric procedures:

- A description of the risks, benefits and consequences of telemedicine;
- The patient retains the right to withdraw from receiving treatment via telemedicine at any time;
- All existing confidentiality protections apply to the telemedicine encounter;
- The patient has the right to access to all transmitted medical information; and

- Notice that there will be no dissemination of any patient images or information to other entities without further written consent from the patient.

(*Medi-Cal Provider Manual: Telehealth.*)

Real-Time, Interactive E&M Services

Though not covered by Medicare, Medi-Cal covers the following E&M services when provided via telehealth during a real-time interaction with the patient at an approved originating and distant site:

- Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (CPT code 90863); and
- Consultations: Office or other outpatient, initial or follow-up inpatient, and confirmatory (CPT-4 codes 99241–99255).

(*Medi-Cal Provider Manual: Telehealth.*)

Asynchronous, Store-and-Forward Ophthalmology and Dermatology E&M Services

Unlike Medicare's coverage exclusion for asynchronous, non-interactive telehealth services, Medi-Cal covers select asynchronous E&M services in which medical information is transmitted to an ophthalmologist or dermatologist to be reviewed at a later time for diagnostic and treatment purposes. The originating site facility fee is reimbursable only to the originating site when billed with HCPCS code Q3014. Transmission costs incurred from providing telehealth services via audio/video communication is reimbursable when billed with HCPCS code T1014 (telehealth transmission, per minute, professional services bill separately).

Store and forward teleophthalmology and teledermatology is a medical service separate from an interactive telemedicine consultation and must meet the following requirements:

- The images must be specific to the patient's condition and adequate for meeting the procedural definition of the national code that is billed.
- Teleophthalmology and teledermatology by store and forward must be rendered by a physician who has completed training in an Accreditation Council for Graduate Medical Education (ACGME)-approved residency in ophthalmology or dermatology respectively.

- A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician consulted through store and forward, upon request. If requested, communication with the distant specialist physician may occur either at the time of consultation or within 30 days of the patient's notification of the results of the consultation.
- The health care provider shall comply with the informed consent provision of §2290.5 of the Business & Professions Code when a patient receives teleophthalmology and teledermatology by store and forward.
- Teleophthalmology and teledermatology does not include single mode consultations by telephone calls, images transmitted via facsimile machines or electronic mail.

The covered E&M services for teleophthalmology and teledermatology are the following:

- Office consultation, new or established (CPT-4 codes 99241–99243);
- Initial inpatient consultation (CPT-4 codes 99251–99253);
- Office or other outpatient visit (CPT-4 codes 99211–99214); and
- Subsequent hospital care (CPT-4 codes 99231–99233).

(Medi-Cal Provider Manual: Telehealth.)

Medicare-Covered Services NOT Covered under Medi-Cal

In light of these more generous Medi-Cal telehealth coverage options discussed above, Medi-Cal does not currently cover the following services and billing codes provided via telehealth that are otherwise covered under Medicare, including but not limited to:

- Psychotherapy consultations (90785, 90833, 90834, 90836, 90838–90840, 90845–90847);
- Diabetes management (HCPCS codes G0108, G0109);
- Counseling for lung cancer screening need (HCPCS code G0296);

- Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services (HCPCS codes G0396 and G0397);
- Follow-up inpatient telehealth consultations (HCPCS codes G0406–G0408);
- Initial inpatient telehealth consultations (HCPCS codes G0425–G0427);
- Tobacco use counseling (HCPCS codes G0436, G0437);
- Annual alcohol misuse screening (HCPCS code G0442);
- Brief face-to-face behavioral counseling for alcohol misuse (HCPCS code G0443);
- Annual Depression Screening (HCPCS code G0444);
- High-intensity behavioral counseling to prevent sexually transmitted infections (HCPCS code G0445);
- Annual, face-to-face Intensive behavioral therapy for cardiovascular disease (HCPCS code G0446);
- Face-to-face behavioral counseling for obesity (HCPCS code G0447);
- Pharmacologic management (HCPCS code G0459);
- Telehealth consultations for critical care (HCPCS code G0506);
- End Stage Renal Disease (ESRD) related services (CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961 and 90963–90970);
- Individual Medical Nutrition Therapy (HCPCS code G0270 and CPT codes 97802–97804);
- Neurobehavioral status exam (CPT code 96116);
- Patient and caregiver focused risk assessment consultations (CPT codes 96160, 96161);
- Individual health and behavior assessment and intervention (CPT codes 96150–96154);
- Nursing care (CPT codes 99307–99310);

- Prolonged services for inpatient and office visits (CPT codes 99354–99357);
- Behavioral change services for smoking (CPT codes 99406, 99407); and
- Transitional and advanced care management (CPT codes 99495–99498).

FRAUD AND ABUSE

Antikickback

Under the federal antikickback statute, it is a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by any federal health care program. (42 U.S.C. §1320a-7b.) The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services is responsible for publishing advisory opinions interpreting the antikickback statute and, until recently, had only published two advisory opinions addressing telemedicine-related issues over the past two decades. The first advisory opinion addressed an arrangement between an ophthalmologist and an optometrist for free telemedicine consultations for the optometrist’s patients by the ophthalmologist in which the ophthalmologist leased the necessary telemedicine equipment to the optometrist. (98 Ops. Off. Inspector Gen. 18 (1998).) The optometrist could also use the equipment to provide other services to the patients independent of the telemedicine consultations. However, the OIG determined that the arrangement did not implicate the antikickback statute because: 1) the lease agreement for the equipment complied with the equipment lease safe harbor requirements; 2) patients referred for ophthalmologist services pursuant to the free telemedicine consultation were allowed the opportunity to choose any ophthalmologist to provide the recommended services; and 3) the ophthalmologist’s free telemedicine consultations only resulted in minimal and incidental business benefits for the optometrist.

In 1999, the OIG issued an advisory opinion related to the possible fraud exposure upon the expiration of a federal grant supporting a rural telemedicine network. (99 Op. Off. Inspector Gen. 14 (1999).) The OIG found that the health system’s ongoing financial support of telemedicine equipment provided to rural health care providers would not violate the antikickback statute primarily because of the clear Congressional intent that

network support was expected to continue beyond the term of the grant to establish much-needed telemedicine infrastructure in rural areas across the United States.

The more recent advisory opinion, published September 6, 2011, is a significant development in the efforts to remove barriers to the widespread adoption and use of telemedicine. (11 Ops.Cal.Atty.Gen. 12 (2011).) The opinion addressed a nonprofit health system’s proposal to provide valuable neuro emergency clinical protocols and technological devices and services to community hospitals to facilitate immediate consultations with stroke neurologists via telemedicine. On its face, the arrangement would classify as a prohibited arrangement not meeting any antikickback safe harbors because it involved the free provision of valuable items and services from one hospital to many other hospitals—with all hospitals having the ability and history of referring Medicare business to and from each other.

The dilemma presented in this opinion is a common issue that stops most telemedicine projects in their tracks. Telemedicine projects inherently require large upfront investment to develop the technology infrastructure necessary to realize the much larger cost-reduction, efficiency and quality of care benefits for Medicare patients and private-pay patients alike.

However, the OIG took a progressive step in this opinion by recognizing this antikickback barrier to telemedicine projects across the country. The OIG permitted the proposed arrangement for the following reasons:

- The objective of the telemedicine project was to reduce the number of transfers of stroke patients to the funding hospital in circumstances where those patients may be managed at the local hospital if telemedicine resources were available.
- Neither the volume or value of a hospital’s previous or anticipated referrals, nor the volume or value of any other business generated between the parties, would be a condition of participation in the telemedicine project.
- The primary beneficiaries of the telemedicine project would be the stroke patients who, with the funding hospital’s support, could be treated at the local hospital emergency departments, when treatment is most effective. It would also benefit the patients who need the more advanced level of

care that the funding hospital can provide, but who might not otherwise have been able to receive it due to capacity issues.

- The timely treatment of stroke patients would likely decrease the incidence of stroke-related disabilities, which, in turn, would likely decrease the costs associated with treating and supporting such patients.

In short, the OIG's opinion could be interpreted as permitting an otherwise prohibited antikickback arrangement in the event that the telehealth project would ultimately result in the delivery of the right care at the right time and place that would not otherwise have been possible through a traditional in-person encounter.

In addition to the advisory opinions, there have been two antikickback cases associated with telehealth activities. In *United States v. Greber* (3d Cir. 1985) 760 F.2d 68, an osteopathic physician was convicted of Medicare fraud for paying illegal remuneration to other physicians in return for referring patients for cardiac monitoring services performed by his company, Cardio-Med, Inc. in which the data were stored in the device while the patient was wearing it, later uploaded to a computer, and interpreted by the osteopathic physician at the Cardio-Med facility. In a similar case, *United States v. Polin* (7th Cir. 1999) 194 F.3d 863, a physician was convicted of Medicare fraud for making cash payments to a cardiac devices sales representative in return for each patient referred to the physician's remote cardiac monitoring company, CVS.

False Claims Act and Civil Monetary Penalties

Medicare regulations explicitly require health care practitioners to be licensed to provide the services by the applicable state entity. (42 C.F.R. §410.20(b).) Thus, the federal laws governing submission of false or fraudulent claims to the government, the False Claim Act (FCA) and the Civil Monetary Penalties (CMPs) authority of the OIG, could be applicable to certain telehealth activities that reach across state lines if appropriate licensure precautions are not taken when claims are submitted to Medicare or state Medicaid programs for reimbursement. (31 U.S.C. §3729; 42 U.S.C. §1320a-7a(a).) The same could apply to claims submitted to

private payors and state Medicaid programs for any similar state variations on the federal FCA.

MEDICARE RULES FOR HOSPITAL CREDENTIALING

Because most hospitals are Medicare-participating providers, the use of telehealth by providers in the hospital setting must be compliant with the Medicare Conditions of Participation (COP) rules, even if no one involved will be seeking Medicare Part B reimbursement for the telehealth encounter. Thus, these rules must be considered by any physician who offers to provide telehealth services to patients in a hospital setting.

The COPs specific to telehealth services require hospitals to have written medical staff bylaws and contract provisions describing how the hospital plans to credential and privilege telehealth physicians who are allowed to provide care to hospital patients. (42 C.F.R. §§482.12(a)(9), 482.22(a)(4).) Medicare allows a hospital to keep all telehealth physician credentialing in-house *or* to rely on the credentialing and privileging processes of a third party. Whichever process the hospital chooses, the hospital's decision must be memorialized in writing in the medical staff bylaws and in the hospital's contract with the telehealth provider. These documents must include the terms Medicare has specifically designated in its COPs. (*Id.*)

It is also important for physicians to understand that, until 2011, the Medicare telehealth credentialing standards were more stringent than the equivalent Joint Commission standards. In 2011, Medicare aligned its standards with those of the Joint Commission. (76 Fed.Reg. 25550, 25550–25565 (May 5, 2011).) Now, both CMS and the Joint Commission allow hospitals to rely on the credentialing of telehealth providers of other hospitals, or even on independent credentialing entities, by proxy (Joint Commission Standard MS.13.01.01 (2019)). With the passage of A.B. 415 discussed above, California has also brought its hospital licensing standards for telehealth provider credentialing in line with the Medicare and Joint Commission standards that allow reliance on another hospital's provider credentialing by proxy. (Business & Professions Code §2290.5(h).)

PRESCRIBING OR DISPENSING VIA TELEHEALTH

When prescribing or dispensing medications via telehealth or the Internet, physicians must have the proper licensure to do so and must establish a proper physician–patient relationship. Regardless of who the payor is, every telemedicine encounter is also subject to what the state medical board has defined as the permissible use of technology for establishing a proper patient–physician relationship, in lieu of a traditional in-person encounter, for the service in question. In some instances, a live audio and video feed between the physician and patient would be mandated by state medical practice law, but in other circumstances a mere telephone call could suffice under the law.

Proper Physician–Patient Relationship

Under California law and common law in most states, a physician may not prescribe medications “without an appropriate prior examination and medical indication.” (Business & Professions Code §§2242, 2242.1.) The law does not provide further guidance on what qualifies as an “appropriate” examination, but the following excerpt from the legislative history of this statute provides physicians with helpful, though non-binding, guidance:

[Appropriate] Prior Examination is a Standard of Care Issue. Rather than define in statute what constitutes [an appropriate] prior examination, the law treats the concept as a standard of care issue. That is, it is judged based on the specific facts of a particular case, and is inherently subjective. Thus, in some circumstances, it is entirely reasonable for a physician to conduct the good faith prior examination without being physically present with the patient. Depending on the records possessed by the physician, the symptomology presented, and the history between the patient and the physician, a web-based examination could meet the standard of care.

(Cal. Sen. Com. on Bus. & Prof., com. on Cal. Sen. Bill No. 1828 (2000 Reg. Sess.), par. 3.) In addition, the Medical Board of California has provided the following unofficial guidance:

This examination, however, need not be in-person, if the technology is sufficient to provide

the same information to the physician if the exam had been performed face-to-face. A simple questionnaire, however, without an appropriate examination would be a violation of law, and would be a disciplinable offense.

Physicians, however, should be aware that other states have adopted laws or medical board position statements that restrict the circumstances under which medications may be prescribed via technology by requiring the physician to interact with the patient, at a minimum, via a live audio and video feed to allow for a real-time exchange. Many of the state authorities also expressly prohibit physicians from prescribing medications based solely on a telephone interaction between the physician and patient, unless an express exception applies (e.g., such as a call coverage exception or a preexisting in-person relationship between the patient and physician).

Similar to what many other states have expressly codified, it appears that the California Medical Board takes a similar enforcement approach, prohibiting telephone-only prescribing:

A good faith prior examination includes taking a history and performing a relevant physical examination. The physical examination is an essential part of the good faith prior examination because it provides the treating physician with additional information about the presenting complaint, the opportunity to observe and assess the patient. Before prescribing a dangerous drug, a physical examination must be performed. A physician cannot do a good faith prior examination based on a history, a review of medical records, responses to a questionnaire and a telephone consultation with the patient, without a physical examination of the patient.

(emphasis added). See *In the Matter of Jon Steven Opsahl, M.D.*, “Decision and Order,” Medical Board of California, Case No. 23-2001-127009, OAH No. L2001110550 (Jan. 21, 2003).

Federal law has a similar restriction for physicians prescribing controlled substances, as enforced by the U.S. Drug Enforcement Agency (DEA), which requires, at a minimum, a live video interaction between the physician and patient. The federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008 bans the sale or distribution of certain

prescription drugs over the Internet without a “valid prescription.” (21 U.S.C. §§829(e), 802(a)(50)–(56), 802(b)–(d), 830.)

In addition to other restrictions, the law requires physicians to personally perform a physical examination of a patient before prescribing any controlled substance, unless an express exemption under the law applies. (21 U.S.C. §§802(54)(A), 829(e)(3); 42 U.S.C. §1395m(m)(1); 42 C.F.R. §410.78(a)(3).) One of the useful exemptions under this law applies to patients who are being treated in certain licensed facilities at the time of the telehealth encounter. This exemption essentially permits a telehealth provider to prescribe a controlled substance to a patient without an in-person physical exam in most circumstances, so long as the following three conditions are met:

- The patient is being treated by, and physically located in, a DEA-registered facility during the telehealth encounter;
- The telehealth physician is registered with the DEA in the state in which the patient is physically located during the telehealth encounter; and
- The telehealth physician interacts with the patient using a two-way, real-time interactive audio and video communications system during the telehealth encounter

(*Id.*) In all, the legal standards for the proper use of technology when prescribing medications for patients is an evolving legal issue that varies greatly depending on the nuances of the telemedicine business model and technology use in question.

Self-Screening Tools

Effective January 1, 2016, a physician and surgeon, or a registered nurse, certified nurse midwife, nurse practitioner, physician assistant acting within their scope and under the supervision of a physician or a pharmacist acting pursuant to Business & Professions Code §4052.3 may use a self-screening tool for purposes of identifying patient risk factors for the use of self-administered hormonal contraceptives by the patient. Patient risk factors that may be self-reported using the self-screening tool includes blood pressure, weight, height, and patient health history. The use of the self-screening tool does not take the place of the required appropriate prior examinations prior to prescribing, furnishing, or dispensing self-administered hormonal

contraceptives to the patient. (Business & Professions Code §2242.2; S.B. 464, Stats. 2015, ch. 387.)

Licensing

While there have been efforts towards interstate licensure to facilitate telehealth across state lines, courts have yet to offer much guidance on the legal parameters of acceptable multistate telehealth practice involving prescription medications and the *Hageseth v. Superior Court of San Mateo County* opinion has set the tone for criminal liability for physicians who prescribe medications across state lines. (*Hageseth v. Superior Court of San Mateo County* (2007) 150 Cal.App.4th 1399.) The California state appellate court in *Hageseth* allowed California to criminally prosecute a Colorado-licensed physician for the unlicensed practice of medicine in California through telehealth. In *Hageseth*, a Stanford student, John McKay, obtained a prescription for Prozac from Dr. Hageseth in Colorado after completing an Internet questionnaire. Unfortunately, John McKay died of a drug overdose shortly thereafter.

Prior to *Hageseth*, these Internet prescribing problems were handled by administrative and criminal proceedings under the theory that the physician violated DEA rules and the standard of care by not establishing a proper physician–patient relationship prior to prescribing the controlled substance. The *Hageseth* court took a different approach and held that California could criminally prosecute Dr. Hageseth for the unlicensed practice of medicine in California because he had reached into California through telehealth and, thereby, had invoked the California medical licensing laws.

Interestingly, the federal Drug Enforcement Agency (DEA) has cited to this *Hageseth* opinion and reasoning to support DEA sanctions in the Internet prescribing context. *See, e.g.,* Ladapo O. Shyngle, M.D., Denial of [DEA] Application, 74 Fed.Reg. 6056, 6058–59 (Feb. 4, 2009); Joseph Gaudio, M.D., Suspension of [DEA] Registration, 74 Fed.Reg. 10083, 10091–93 (Mar. 9, 2009); Patrick W. Stodola, M.D., Revocation of [DEA] Registration, 74 Fed.Reg. 20727, 20731–74 (May. 5, 2009). Though criminal prosecution for the unlicensed practice of medicine through multistate telehealth activities has been academically discussed as a possibility in the telehealth industry, *Hageseth* and the DEA made that theory a reality and a considerable risk for healthcare practitioners participating in multistate telehealth activities.

FDA GUIDANCE ON TELEHEALTH SOFTWARE, DEVICES AND MOBILE APPS

As the use of technology becomes ubiquitous in health care, the need for regulation of new software, devices and mobile apps has surfaced. Prior to 2013, telehealth providers were essentially operating without any specific guidance from the U.S. Food and Drug Administration (FDA) that addressed the parameters of the FDA's regulation over telehealth-specific software, devices and mobile apps. From one perspective, guidance was much needed because of the unique questions presented with technology in healthcare, i.e., where the line is drawn on what is a regulated medical device in the virtual world of telehealth. Another perspective was that any guidance would only create more confusion in the industry. Over the past year, the FDA has not disappointed either perspective.

On September 25, 2013, the FDA published a final guidance on the application of its regulatory oversight to mobile medical apps. (FDA, *Mobile Medical Applications: Guidance for Industry and Food and Drug Administration Staff* (Sept. 25, 2013).) This sweeping guidance essentially subjected many telehealth ventures to the possible regulation of the FDA. After much clamoring from the industry, however, on June 19, 2014, the FDA provided another guidance document on the topic that reigned in much from the initial guidance document. (FDA, *Medical Device Data Systems, Medical Image Storage Devices, and Medical Image Communications Devices* (June 19, 2014).) As stated in the 2014 guidance document:

[T]he FDA does not intend to enforce compliance with the regulatory controls that apply to MDDS devices, medical image storage devices, and medical image communications devices ... Medical Device Data Systems (MDDS) are hardware or software products that transfer, store, convert formats, and display medical device data. A MDDS does not modify the data, and it does not control the functions or parameters of any connected medical device. MDDS are not intended to be used in connection with active patient monitoring.

(*Id.*) This was positive news for many telehealth providers because it minimized the FDA regulatory

hurdles for many involved in the telehealth industry, e.g., those who merely utilize MDDS-like technology to facilitate a telehealth encounter. However, even under the new guidance document, many telehealth providers will still likely be subject to FDA regulation as purveyors of "low-risk" FDA classified device. Thus, this appears to be an evolving issue and more will likely come from the FDA on the parameters of its regulation over the telehealth industry.

For more information, visit the FDA website on Mobile Medical Applications at www.fda.gov/medicaldevices/digitalhealth/mobilemedicalapplications/default.htm.

FTC'S INVESTIGATIONS

Similar to the recent uptick in FDA involvement, the United States Federal Trade Commission (FTC) has recently been exerting its authority over healthcare technology in a manner that has begun to have a considerable impact on the telemedicine industry.

In February 2015, the FTC fined marketers of two mobile health apps based on alleged misleading advertising materials by marketers claiming that the apps could be used to diagnose and assess the risk of melanoma. (Federal Trade Commission Press Release, *FTC Cracks Down on Marketers of 'Melanoma Detection' Apps* (February 23, 2015), available at www.ftc.gov/news-events/press-releases.) The entities fined by the FTC were Health Discovery Corp., which provides marketing services for MelApp, and New Consumer Solutions, the developer and marketer of Mole Detective. It is notable that this government involvement came from the FTC, as opposed to a state medical board investigation into the unlicensed practice of medicine by the mobile app marketers, which is a criminal violation under California law.

In a similar FTC investigation, on September 17, 2015 the FTC announced that it had fined the California-based marketers of a software app, Carrot Neurotechnology, Inc., \$150,000 because they had allegedly made deceptive claims that their "Ultimeyes" app can improve user's vision. (Federal Trade Commission Press Release, *FTC Charges Marketers of 'Vision Improvement' App With Deceptive Claims* (September 17, 2015) available at www.ftc.gov/news-events/press-releases.) As explained by Jessica Rich,

Director of the Bureau of Consumer Protection for the FTC “Health-related apps can offer benefits to consumers, but the FTC will not hesitate to act when health-related claims are not based on sound science.”

Thus, physicians involved in telemedicine projects should scrutinize the technology, and related marketing materials, they are using to facilitate their telemedicine encounters. The physician versus technology role in clinical decision-making should be clearly delineated in marketing and website materials to avoid unnecessary scrutiny, and potential sanctions, from the FTC.

TELEHEALTH-RELATED LAWS AND HELPFUL RESOURCES

Physicians should also keep in mind that telehealth ventures often implicate other California and federal laws and regulatory authority that are beyond the telehealth laws discussed above, such as the following:

- Automated delivery of prescription medications (Health & Safety Code §1261.6; Business & Professions Code §4119.1);
- Telephone medical advice services (Business & Professions Code §§4999 *et seq.*; 16 C.C.R. §§4000 *et seq.*);
- Medical board telehealth pilot project (Business & Professions Code §2028.5);
- Internet posting of lab results (Health & Safety Code §123148); and
- The federal healthcare reform law (references throughout regarding quality of care and funding for remote delivery and monitoring of healthcare services via electronic means).

The following websites provide additional telehealth resources for physicians:

- California Telehealth Resource Center, www.caltrc.org/;
- California Telehealth Network, www.caltelehealth.org/;
- Medical Board of California: *Practicing Medicine Through Telehealth Technology*, www.mbc.ca.gov/Licensees/Telehealth.aspx;
- American Telemedicine Association, www.americantelemed.org/;
- Center for Telehealth and E-Health Law, <http://ctel.org/>; and
- Federation of State Medical Boards, www.fsmb.org/.

We hope this information is helpful to you. CMA is unable to provide specific legal advice to each of its more than 44,000 members. For a legal opinion concerning a specific situation, consult your personal attorney.

For information on other legal issues, use CMA’s online health law library, CMA ON-CALL, or refer to the *California Physician’s Legal Handbook* (CPLH). CPLH is a comprehensive health law and medical practice resource containing legal information including current laws, regulations and court decisions that affect the practice of medicine in California. Written and updated by CMA’s Center for Legal Affairs, CPLH is available in an eight-volume, soft-bound print format, or as an online subscription to www.cplh.org. To order your copy, call (800) 882-1262 or visit CMA’s website at www.cmadoocs.org.