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COPIC INSIGHT:

Navigating the Medical Liability Aspects of Telehealth

FEBRUARY 2022

COPIC INSIGHT: Navigating the Medical Liability Aspects of Telehealth

2023 SUPPLEMENT AND UPDATES

This Supplement covers important changes to the COPIC publication, *COPIC Insight: Navigating the Medical Liability Aspects of Telehealth*, published in February 2022.

In January 2020, the COVID-19 Public Health Emergency (PHE) provided "flexibilities" or "enforcement discretion" for some federal rules to allow wider access to telehealth; many states similarly adjusted their telehealth rules. Some of these federal and state "relaxations" were intended to be temporary.

The federal PHE declaration officially expired on May 11, 2023. By then, many states had already canceled licensure waivers or other legal accommodations. These actions have changed the regulatory environment for telehealth in significant ways.

Providers of telehealth services under the rules of the 2020 PHE need to review and comply with changes in federal and state regulations now in effect—and which will undergo further changes on specific dates through 2024.

COPIC's telehealth booklet offers guidance and suggestions for best practices that remain relevant in 2023 and beyond. However, some sections on legal and regulatory issues must now be revised. 2023 has brought legal regulatory changes on relatively short notice—and more provisions are in public comment periods or undergoing agency reviews. This update is to help providers of telehealth services keep current with regulatory requirements as they evolve.

The following sections of COPIC's telehealth booklet have been revised. Page numbers refer to the February 2022 version which is available online at **www.callcopic.com/resource-center/guidelines-tools/practice-management-resources** or in printed form on request (720) 858-6000.

OVERVIEW [p. 1]

Even before the expiration of the federal COVID-19 Public Health Emergency declaration on May 11, 2023, many states had already rescinded their own regulatory "flexibilities." As of August 9, 2023, most federal telehealth accommodations have reverted to their pre-COVID status, with a few exceptions.

- Congress has extended some payment considerations for Medicare and Medicaid through 2024.
- The DEA has extended certain waivers pertaining to prescribing controlled substances until November 11, 2024, with specific restrictions.

Telehealth regulations will largely remain favorable for providers licensed in the state where the patient is physically located at the time of service. However, for providers delivering services where they are not licensed, restrictions vary widely by state and need to be closely monitored.

The longstanding practice of states allowing limited care and prescribing by out-of-state providers to established patients who are temporarily visiting remains essentially intact. But ironically, telehealth has increased scrutiny by states upon every type of service by unlicensed practitioners. A few have even looked more closely at telephonic (audio only) care, which some are considering a subset of telehealth.

LICENSURE [p. 4]

During the declared PHE, a number of states waived some licensure provisions through executive orders. By 2023, all such waivers expired. Most states have reverted to requiring full state licensure for practitioners who deliver telehealth services to patients located within their borders.

However, more than a dozen states have created limited licenses or registries that allow telehealth services by out-of-state providers. Application processes can be found on state medical board sites.

Telehealth providers who wish to offer services in jurisdictions where they are not licensed are advised to contact each relevant state agency to understand their legal requirements. This is understandably burdensome. Hopefully mechanisms to facilitate interstate telehealth more easily will be devised in coming years.

PRIVACY AND SECURITY [p. 4]

This section remains technically correct under new HIPAA rules following the expiration of the PHE. However, it is important to emphasize that certain "enforcement flexibilities" applicable during the COVID-19 emergency expired on May 11, 2023. Some of these included:

- Allowing the use of technology platforms that did not strictly comply with HIPAA encryption requirements or other security standards.
- Waiving certain documentation requirements at virtual visits (such as providing a Notice of Privacy Practices and collecting an Acknowledgment of Receipt of Notice of Privacy Practices).

The points noted in this section could be understood as "best practices" during the PHE; however, at this time they should be interpreted as "requirements."

PRESCRIBING [p. 5]

State laws determine whether an in-person visit is required before writing a prescription for drugs that require a professional license. Federal laws determine whether an in-person visit is required before prescribing drugs controlled by the DEA.

During the COVID-19 emergency, the DEA waived the prior in-person requirement for practitioners otherwise authorized to prescribe controlled substances to patients via telehealth. This allowed practitioners to write prescriptions for controlled substances based on a "virtual" visit.

- The DEA is allowing patients who established a "virtual" relationship with the prescribing provider to receive prescriptions for controlled substances via telehealth until **November 11, 2024**. After that, an in-person visit (or possibly some form of referral) will be required.
- However, this waiver applies only if the patient establishes a "virtual" relationship before **November 11, 2023**.
- Patients who have not established a relationship by November 11, 2023, must do so in person to be eligible to receive prescriptions for controlled substances via telehealth.

It is expected that most states will follow the DEA rule by default; however, practitioners need to comply with any additional state provisions for prescribing controlled substances where they are licensed. Prescribers with patients in multiple states need to comply with each state's applicable laws and regulations (for example, checking the state PDMP), including licensure requirements.

It is expected that the states will continue the longstanding practice of allowing out-of-state providers to order prescriptions (controlled substances and otherwise) for established patients who are temporarily visiting, under certain conditions. Providers should communicate with the local pharmacist about whether a PDMP search is required and how it should be done.

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COPIC INSIGHT is an exclusive resource for COPIC-insured individuals, practices, and facilities. It provides insight on timely issues in health care, along with resources to help insureds address these in their own setting.

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* Information in this publication is for general educational purposes and is not intended to establish practice guidelines or provide legal advice.

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OVERVIEW

SEE 2023 SUPPLEMENT AND UPDATES

The use of telehealth has grown rapidly and emerged as a popular and effective option that many medical providers are embracing. The telehealth environment presents many benefits, but there are also challenges and risks that medical providers need to be aware of and manage.

This booklet focuses on telehealth issues from a medical professional liability perspective; it highlights some key considerations for insureds and policyholders. Some important questions when looking at telehealth include:

- Does telehealth impact claims trends or patterns of adverse outcomes?
- Are there any issues to consider in how telehealth is used by different medical specialties and/or practice settings?
- Do any telehealth services create added concerns for patient safety?
- How do standards for telehealth care differ from those for in-person care?
- How do we manage legal and coverage complications arising from practice across state lines?

These questions and others are being discussed by legislators, guideline development organizations, technology companies, legal scholars, and health care experts, as they seek to distribute the benefits of new technologies in health care while protecting patients and society from hazards, abuses, and errors.

In the wake of COVID-19, several factors converged to make the recent telehealth expansion possible:

- "Relaxation" of federal and state regulations that previously encumbered telemedicine, including licensure, HIPAA, DEA, and Medicare rules.
- Executive orders by state governors and licensing boards "waiving" restrictions that were impediments.
- Changes to payment policies by Medicare, Medicaid, and commercial carriers that created "parity" or at least attractive levels of reimbursement.
- A variety of available and aggressively marketed, mature telemedicine platforms, sometimes integrated with existing EHRs.
- Widespread acceptance (though sometimes reluctantly) of remote video conferencing as a "new normal" by schools, businesses, governments, and industries apart from health care.

TERMINOLOGY

We have chosen to use the terms "telehealth," "telemedicine" and "telecare" interchangeably. Some authorities define them differently, based on nuances about platforms, scope, beneficiaries, technologies, clinical applications, etc. However, statutes, regulations, and the legal and clinical literature use these words inconsistently, which makes settling on a standard definition potentially confusing.

Telehealth service (or telemedicine, telecare) is typically delivered in real time via a teleconferencing platform. It may include data channels for physiologic monitoring or record review. In some states, audio-only encounters (e.g., telephone) may fall under the definition of telehealth. This includes telephone calls, which for decades fell entirely under the radar. "Store and forward" services (e.g., teleradiology or remote monitoring, where a clinical recording is reviewed after an interval) are also considered forms of telehealth. In addition, there are discussions around whether email or portal messages to out-of-state patients might constitute "practicing" in those jurisdictions.

It is an open question whether a surge in new claims is pending in the pipeline, or whether, for reasons not entirely clear, telehealth may simply entail lower risk than in-person care. The position COPIC has taken regarding telehealth practice is to welcome and support it as a valuable enhancement to the delivery system. We see a future in which patients' access to care is meaningfully enhanced by this technology, lowering longstanding barriers of geography, logistics, economics, and other factors. We also expect significant changes in legal, regulatory, clinical, and organizational processes to accompany the shifts brought about by telehealth and its expanded use.

COVERAGE CONSIDERATIONS

As telemedicine encounters become more commonplace, it's important to be familiar with how medical liability insurance coverage applies and the issues that may differ from face-to-face encounters. In general, COPIC's policies do provide coverage for telemedicine, however, important areas to consider in determining the scope of coverage are highlighted in this section. Changes in the services offered and/or other significant practice changes should be discussed with your agent and/or COPIC underwriter to confirm an understanding of coverage.

POLICY DEFINITIONS

COPIC's policy includes definitions of "medical incident," "medical services," and "telehealth/telemedicine" as defined below:

- ***Medical incident*** *means any alleged act or omission in furnishing or delivery of* ***medical services****, by you or any person under your control and supervision. Multiple acts or omission related to your provision, furnishing or delivery of* ***medical services*** *in a continuing course of care that result in an injury or damages will be considered one* ***medical incident*** *only.*
- ***Medical services*** *means the provision of professional services within the limits of your professional license, certification or registration, including* ***telemedicine****, medical treatment and diagnosis and rendering medical opinions or medical advice.*
- ***Telemedicine*** *means the provision of* ***medical services*** *to a patient in another location through the use of technology, with or without an intervening health care provider.*

Based upon these definitions, COPIC's professional liability coverage includes telemedicine practice, under appropriate conditions.

TERRITORIAL RESTRICTIONS/STATE CONSIDERATIONS

Most policies define the territory in which a claim will be covered, or where it must be filed for coverage to be available. While some policies may limit the insurance coverage to the state where the policy is issued (i.e., a single state), others may include worldwide coverage, so long as the claim/suit is brought within the United States.

COPIC's policies have the following territorial restriction language: *This policy provides coverage only for any covered claim made and filed in the United States of America, its territories or possessions.*

When working outside of your principal state and providing telemedicine services to patients in other states, it is important to be aware of any state-mandated or optional Patient Compensation Funds (PCFs) that are available. As of February 2022, states having these are Indiana, Kansas, Louisiana, Nebraska, New Mexico, New York, Pennsylvania, South Carolina, and Wisconsin. An insured medical provider who is providing patient care in these states may be required to enroll in the PCF and premium surcharges may apply.

EXCLUSIONARY LANGUAGE

Review of policy exclusions should be completed to determine how any exclusions might apply to telemedicine services. Standard policy exclusions will generally continue to apply, such as those that are considered business and employment-related activities, criminal acts, disputes on fees, etc.

COPIC's policies include the following exclusion, which would apply if a provider were not considered properly licensed, certified, registered, etc., in the state in which they are providing telemedicine services:

- ***Exclusion****—Any act or omission when the provider is not properly licensed, certified or registered to provide the medical services, or when the provider was violating the terms of any denial, restriction, reduction, suspension or revocation of his or her license, certification, registration or hospital or clinical practice privileges, except for a temporary restriction due to incomplete medical records.*

LIMITS OF LIABILITY

Given that each state develops its own rules/laws, there may be changes in financial responsibility requirements, depending on the state in which medical care is considered to be practiced and delivered. Review of the limits on your policy and any state-specific requirements should be done in connection with your agent and/or COPIC underwriter for any policy adjustments that may be necessary. In some cases, the limits you maintain may need to be increased or decreased based upon state-specific requirements.

OTHER COPIC COVERAGE RELATED TO TELEMEDICINE

- **Cyber Liability Coverage**—COPIC's policies include limited embedded cyber liability coverage. We encourage policyholders to review this to understand what it covers. This added level of protection includes coverage for not only cyber-related events like phishing or ransomware, but also HIPAA breaches resulting from human error or inadequate policies and procedures. Some examples where cyber coverage may apply to telemedicine include unauthorized access to IT systems, data breach response costs, damages to network assets, business interruption expenses, and cyber extortion expenses. We recommend reviewing the liability limits available for purchase to ensure they align with your practice needs. Please review the separate *COPIC Cyber Liability Coverage* booklet for more details.
- **Covered Proceedings Coverage**—COPIC's policy provides limited defense-only coverage for covered proceedings events that may include incidents arising from telemedicine situations. This includes coverage for billing fraud and abuse investigations, disciplinary proceedings (i.e., responding to a patient complaint to the Medical Board), a governmental investigation or peer review proceeding. See coverage specifics in your policy for additional details.

> Policyholders are encouraged to contact their agent or COPIC if they are embarking upon a telemedicine practice, particularly when providing care outside of your principal state, so that an assessment can be made with respects to the adequacy of their policy.

LEGAL AND REGULATORY ISSUES

Providing health care services through telemedicine is regulated by a myriad of evolving federal and state laws. The complexity of governmental requirements begins with what is considered telemedicine—an evolving concept that will differ among licensing jurisdictions.

A practitioner's telemedicine services will generally require compliance with federal and state laws as if the practitioner provides the services in an in-person setting, but may include additional requirements that apply in the telehealth setting. This section focuses on three areas as relates to telemedicine: licensure, prescribing authority, and privacy and security. Certainly, other areas apply, such as establishing a practitioner-patient relationship, scope of practice, supervision of advanced practice providers and other staff, informed consent, and more. Some of these areas are discussed in the next section about *Patient Safety/Risk Management Guidelines for Telemedicine*.

LICENSURE SEE 2023 SUPPLEMENT AND UPDATES

Like all forms of health care services, state licensure laws will apply as there is no nationwide license for telemedicine. With limited exceptions, states require health care practitioners that treat patients through telemedicine to be licensed in the state of the physical location of the patient at the time of service. A physician practicing in a state through telehealth is subject to the state's medical practice act and all medical board regulations and policies, and should be familiar with these.

Becoming licensed in several states to perform telemedicine is an arduous application process that is somewhat mitigated by the **Interstate Medical Licensure Compact** (IMLC), a group of 34 states, D.C. and Guam, that seek to streamline the application process **(www.imlcc.org)**. However, please note that the IMLC process still requires a practitioner to obtain licensure from each state's medical board in which the practitioner seeks to provide telemedicine services and to pay the applicable licensing fee. If a practitioner provides health care services in a state without that state's license, the practitioner can be subject to disciplinary action. Additionally, any negative complaint against a practitioner is required to be reported to each state participating in the IMLC.

PRIVACY AND SECURITY SEE 2023 SUPPLEMENT AND UPDATES

Practitioners must also comply with all privacy and security laws (state and federal, such as HIPAA) in a telemedicine setting to generally the same extent that apply when examining or treating a patient in person. The telemedicine technology platform and all patient records and information must be stored, preserved, and secured in compliance with all applicable requirements as in any other setting. Covered health care providers that seek additional privacy protections for telehealth while using video communication products should provide such services through technology vendors that are HIPAA-compliant and will enter into HIPAA business associate agreements in connection with the provision of their video communication products. Additionally, patient records originating from a telemedicine setting must adhere to ONC's Cures Act Final Rule requirements that a patient must have immediate access to his or her medical records.

*Telemedicine technology platforms should be **HIPAA-compliant** and medical records must adhere to **ONC's Cures Act Final Rule** requirements that allow patients immediate access to their records.*

PRESCRIBING SEE 2023 SUPPLEMENT AND UPDATES

Another consideration for telemedicine services is compliance with regulations governing prescribing controlled substances to patients. The authority to prescribe controlled substances originates from the practitioner's state of licensure regardless of the patient setting.

Before COVID-19, prescriptions for a controlled substance issued by means of telemedicine were generally predicated on an in-person medical evaluation (21 U.S.C. 829(e)). However, during the designated public health emergency, DEA-registered practitioners may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
- The telemedicine visit with the patient is conducted using an audio-visual, real-time, two-way interactive communication system; and
- The practitioner is acting in accordance with applicable federal and state laws. Practitioners must be registered with the DEA in at least one state and have permission under state law to practice using controlled substances in the state where the dispensing occurs.

Regardless of whether a public health emergency exists, if the prescribing practitioner previously conducted an in-person medical evaluation of the patient, the practitioner may issue a prescription for a controlled substance after having communicated with the patient via telemedicine, or any other means, so long as the prescription is issued for a legitimate medical purpose and the practitioner is acting in the usual course of his or her professional practice.

In addition, for the prescription to be valid, the practitioner must comply with applicable federal and state laws. The prescribing practitioner should also determine the possible requirement to register and maintain an account with the state's prescription drug monitoring program (PDMP), and consult with the PDMP when prescribing controlled substances.

All other prescribing requirements will apply, such as issuing a prescription either electronically (for schedules II-V) or by calling in an emergency schedule II prescription to the pharmacy, or by calling in a schedule III-V prescription to the pharmacy.

All other prescribing requirements will apply, such as issuing a prescription either electronically (for schedules II-V) or by calling in an emergency schedule II prescription to the pharmacy, or by calling in a schedule III-V prescription to the pharmacy.

COPIC'S PERSPECTIVE

Practitioners that provide services through telemedicine are encouraged to seek legal counsel with respect to the applicable requirements.

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PATIENT SAFETY/RISK MANAGEMENT GUIDELINES FOR TELEMEDICINE

The guiding assumption about telemedicine liability claims is that they will be fundamentally the same as claims seen with in-person care, despite the novelty of the medium, the nature of medical treatment, and the variables that create uncertainty and adverse outcomes. COPIC has been monitoring the legal and clinical literature for reports of new risks related to telemedicine. So far, these have been rare and generally foreseeable. COPIC's risk management attention generally falls into two categories:

Known patient safety risks that require special risk mitigation strategies for telemedicine

- A sudden patient emergency.
- A language or communication barrier.
- Performance of many aspects of the physical examination.
- Identification and management of patients, visitors, minors, assistants, and caregivers in the session.

Novel patient safety risks arising from electronic communication technology

Technology hazards that may impact telemedicine risk:

- Interrupted or inconsistent connection; poor quality audio or video; distortion.
- Intrusion or interception; unauthorized participants.
- Unintended or surreptitious recording.
- Impersonation, misrepresentation, spamming, hijacking, or diverting a session.
- Loss, distortion, or breach of data collected during the session.
- Malfunction of monitoring devices or data streams.

KEY FACTORS THAT INFLUENCE RISK

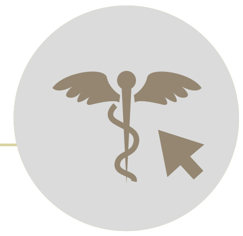
When we look at specific telehealth interactions with patients, risk should also be evaluated based on factors including: the **acuity** of the situation; the **expectations** of the patient, and the presence of other clinicians or a pre-existing **provider/patient relationship**. These factors can either increase or decrease the risk. How each factor affects the risk and some strategies to reduce that risk is outlined as follows.

Acuity

In primary care, acute care, and non-procedural medicine, the majority of claims occur for the allegation of failure or delay in diagnosis. When that failure or delay in diagnosis leads to a preventable or alterable adverse outcome, also known as "missing the window of opportunity," then liability claims of significance can arise.

Acute diagnoses with narrow windows of opportunity include:

- Acute neurologic conditions, such as cerebral vascular accident (CVA), intracranial hemorrhage, encephalitis/meningitis, space occupying lesions, and spinal cord conditions such as spinal epidural abscess (SEA), hematoma, or disc compression of the cord;
- Chest pain including acute coronary syndrome (ACS)/myocardial infarction (MI), pulmonary embolism (PE), and aortic dissection;
- Acute serious infectious disease, including sepsis, pneumonia, septic arthritis, necrotizing fasciitis, and deep abscesses; and
- Acute intraabdominal conditions, including appendicitis, perforated viscus, abscess, ischemic bowel, and ectopic pregnancy.



Careful consideration for these diagnoses coupled with a low threshold for escalation to a higher level of care, including in-person care, referral, or consultation can be a strategy to reduce these "narrow window of opportunity" risks. Documentation that you considered these risks, had a plan to escalate or rule them out, and that plan was consistent with the timeliness necessary to prevent an adverse outcome is also important.

For procedural physicians the highest risks outside of the actual performance of the procedure include:

- Correct patient selection and indications for the procedure, pre-procedure, and;
- Recognition and rescue of patients with complications, post-procedure.

While telemedicine can be used as an adjunct to both pre- and post-procedure care, excellent documentation pre-procedure and a low threshold to escalate to in-person evaluation post-procedure are excellent risk management considerations.

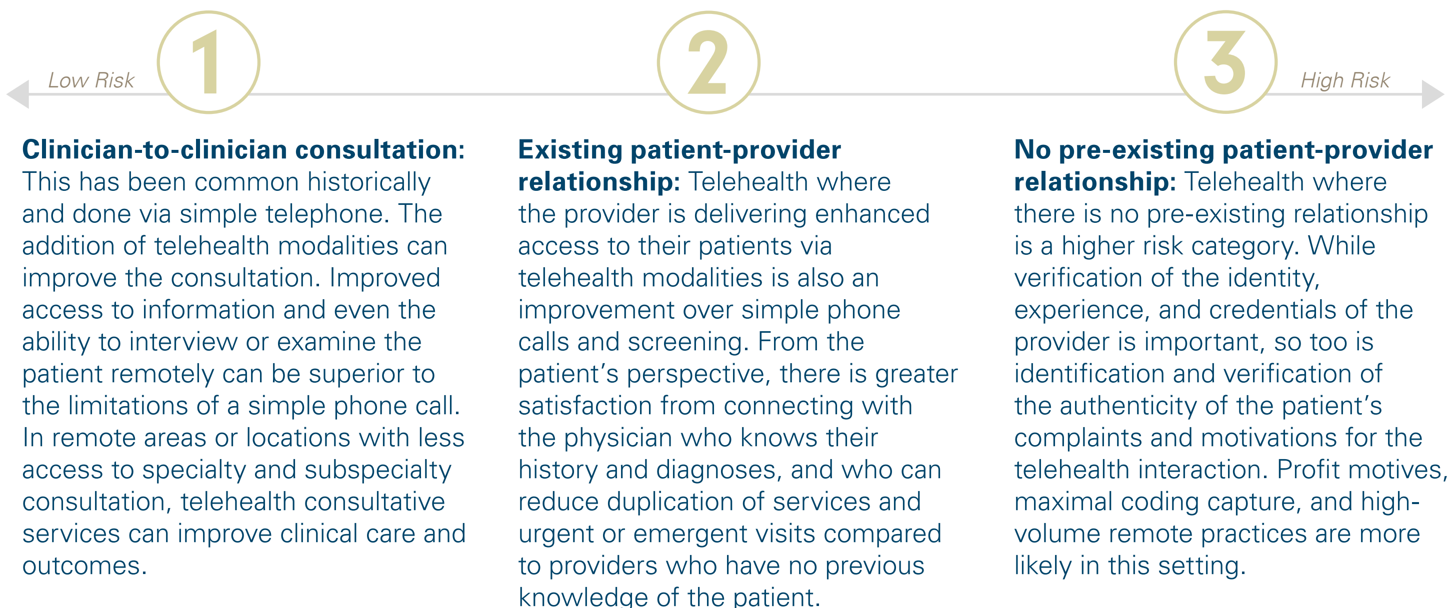
Patient Expectations

Patients who use telehealth in order to avoid hospitalization or medical interventions can be at higher risk. Liberal use of well-documented informed refusal can protect you when adverse outcomes occur due to non-compliance with medical advice. Informed refusal documentation can range from a chart note describing your discussion of the risk and benefits to a more comprehensive informed refusal document that the patient affirms their understanding of by signature or remote confirmation.

> COPIC has a sample informed refusal form that can be downloaded at **www.callcopic.com/resource-center/guidelines-tools/consent-forms**. It is available in a Word document format that can be edited or incorporated into your specific documentation system.

Provider/Patient Relationship

Telehealth broadly falls into 3 categories, which correspond to different risks.



Clinician-to-clinician consultation: This has been common historically and done via simple telephone. The addition of telehealth modalities can improve the consultation. Improved access to information and even the ability to interview or examine the patient remotely can be superior to the limitations of a simple phone call. In remote areas or locations with less access to specialty and subspecialty consultation, telehealth consultative services can improve clinical care and outcomes.

Existing patient-provider relationship: Telehealth where the provider is delivering enhanced access to their patients via telehealth modalities is also an improvement over simple phone calls and screening. From the patient's perspective, there is greater satisfaction from connecting with the physician who knows their history and diagnoses, and who can reduce duplication of services and urgent or emergent visits compared to providers who have no previous knowledge of the patient.

No pre-existing patient-provider relationship: Telehealth where there is no pre-existing relationship is a higher risk category. While verification of the identity, experience, and credentials of the provider is important, so too is identification and verification of the authenticity of the patient's complaints and motivations for the telehealth interaction. Profit motives, maximal coding capture, and high-volume remote practices are more likely in this setting.

PATIENT SAFETY/RISK MANAGEMENT GUIDELINES FOR TELEMEDICINE (CONT.)

SCOPE OF SERVICES

Telehealth services must be consistent with the scope of practice and privileges otherwise provided in an in-person manner.

Telemedicine implies that the provider's scope of practice and expertise for a given clinical situation are equal to that of an in-person traditional encounter. When that is not possible to achieve in a telemedicine setting, escalation to a clinical setting necessary to deliver that scope of practice is necessary. Except in extraordinary circumstances, it will be insufficient as an excuse to claim a different standard or that the limitations of the medium was the reason for the failure or delay in performance.

Regardless of initial screening or triage, there should be a process by which the patient can be referred to the next available provider who has the requisite scope of practice, training, and experience. There should be a backup/contact plan for the rare possibility that a patient experiences an emergency during a telehealth session or the session is interrupted.

INFORMED CONSENT

Practitioners will be held to the requirements in the state where the patient is physically located, whether informed consent for telehealth services needs to be done verbally and/or in writing. The memorialization of that process is not a simple signature, but involves documentation of how it occurred. Several important elements to record include the patient's understanding of the technical aspects of the visit, the limitations of the service, and their acknowledgement that they will comply with recommendations to escalation to other service settings should the health care professional deem it necessary.

DOCUMENTATION

There are some unique aspects of telehealth documentation. A good practice is to note the medium used (e.g., teleconference, phone, telemetry data review, etc.). If any technical issue prevented optimal communication, that should be noted (e.g., "Exam limited by capabilities of the patient's cell phone"). It's required by some states to record the fact that the patient was aware of the limits of the technology and that there was a backup plan if it failed. Extra steps need to be taken to document consent for recording or photography. You should note any additional parties at either end, such as assistants or relatives. If an in-person visit would have been preferable, but was not possible or advisable due to circumstances (e.g., weather, COVID, etc.), this needs to be documented in the disclosure and consent.

Furthermore, the following elements are the minimum necessary for the documentation of a telemedicine visit:

- A statement of technical modality used for the encounter;
- A statement of verbal and/or written consent;
- The customary documentation of the clinical visit. Great care should be exercised to not use templates that imply levels of examination that are impossible to conduct via the telemedicine modality;
- The medical decision making and working diagnosis;
- The plan, including how it was conveyed to the patient and some statement of the patient's understanding and willingness to comply with it;
- In circumstances where escalation to a more clinically intensive service is recommended, there needs to be discussion of that understanding and the patient's intent to comply. It would be ideal if the provider would close the communication loop with the next clinically intensive service by direct communication with them, explaining the medical decision making and why the next service was recommended.

SUPERVISION AND CONSIDERATIONS WITH ADVANCED PRACTICE PROVIDERS (APPs)

APPs are subject to the same considerations of scope of services described previously. Furthermore, in states where supervision is implied or required for APPs, the supervising physician needs to have experience, training, and a scope of practice that includes whatever clinical management is being provided by the APP. Put simply, "You cannot supervise that which you yourself don't have experience and training to do." Some states go further and require "active practice" to be able to supervise that service.

MEDICATION/PRESCRIBING

Prescribing medications over telehealth when the physician and the patient are in the same state and have a pre-existing relationship has the lowest risk and is most similar to prescribing for traditional in-person visits. The risk rises when there is no previous relationship or the patient is located in a different state at the time of the telehealth visit and will need to access follow-up, imaging, consults, referrals, and additional prescriptions in the other state.

Telephoning prescriptions across state lines has traditionally been accepted for established patients. Prescriptions are subject to both federal and state laws. Most states give pharmacists discretion whether to fill or deny a prescription from a provider who is not licensed in that state. This may be decided on a case-specific basis. It is much more likely to trigger licensing requirements and complaints if you do not have a pre-existing relationship with the patient in a state in which you were licensed. That doesn't mean every prescription will be accepted or rejected; it means you can usually rely on the pharmacist to know whether they are allowed to cooperate. It is best to contact the pharmacist directly if there is any question about a prescription in a state where you do not hold a license.

High patient dissatisfaction and even adverse patient outcomes can arise from delays in dispensing medications. And pharmacists who believe that the prescriptions were generated out-of-state and are not in compliance with the local state regulations might feel a need to generate complaints to local licensing boards.

For more information on legal/regulatory considerations when prescribing controlled substances, please see the *Prescribing* section on page 5.

INTERPRETATION SERVICES

The ADA and Limited English Proficiency rules (LEP) apply to telehealth encounter. There are services available that enable the integration and use of remote, qualified interpreters with telehealth platforms.

INTEGRATION WITH EHRs

Being able to generate a unique patient identifier, gather the necessary background information, and access previous records, studies, images, consults, etc. are all challenges in telehealth. It is not a given that an EHR will integrate smoothly with the telehealth application. The pre-visit registration that goes into preparing a patient for an in-person visit remains necessary in the telehealth environment. Efforts should be taken to make sure that telehealth provider have access to existing patient data in real-time.

COPIC RESOURCES FOR TELEHEALTH:

- **24/7 Risk Management Hotline**—Contact a COPIC physician for urgent, after hours guidance at (720) 858-6396.
- **Legal Helpline**—Support from COPIC's Legal Department on issues where medical and legal elements intersect; available 8am–5pm (Mountain time), Mon.–Fri. at (720) 858-6030.
- **COPIC seminars/on-demand courses**—Visit **www.callcopic.com/education** for a current listing of education activities.
- **Medical Guidelines and Tools**—Our website also features downloadable resources such as consent forms (**www.callcopic.com/resource-center/guidelines-tools/consent-forms**) and practice management resources (**www.callcopic.com/resource-center/guidelines-tools/practice-management-resources**).

CYBER RISK

COPIC provides a basic level of cyber liability coverage (embedded in policies) to insureds. It became apparent several years ago that health information technology presented a new category of liabilities for practitioners.

Health care's dependence on electronic data puts hardware, software, and infrastructure at risk of environmental, technical and human mishaps. Health information systems are also subject to attack by hostile actors, including some who are highly skilled and heavily financed. Costs from cyber losses have become a serious concern for insurers.

Telemedicine—as an extension of health information technology—is vulnerable to inadvertent risks like power outages and human error, as well as intentional and malicious risks that arise from its offering an additional "attack surface" for malware, hacking, and fraud.

So far, telemedicine has not produced similar high impact disasters that security and privacy breaches have caused for email, EHRs, financial systems, patient registration, and clinical data. This may be partly because video conferencing technology is newer, narrower, and better designed; and because the volume of telemedicine transactions is magnitudes lower than other health care activities.

However, scrupulous attention must be given to securing and managing telemedicine platforms and their accompanying data. The most vulnerable points where intrusions penetrate health care are where workers interact with external correspondents through email, document exchange, database connectivity, etc. The main cyber risks for telemedicine today are probably:

- Impersonation (of either party)
- Phishing, fraud, and malware encountered during data exchange
- Data loss, corruption, and theft

Privacy breach is perhaps the most sensitive risk in the perception of the public and some regulators. However, the potential use of telemedicine platforms to covertly invade other systems is probably a more serious threat. Risks to telemedicine systems are more likely to enter through connections from clinical, administrative, and other primary systems, rather than by direct interception.

In principle, cyber safeguards for telemedicine are the same as for all information systems. Areas specific to the platform that should be considered are:

- Risk assessment
- Policies, procedures, and training
- Data flow and connectivity

As mentioned previously, COPIC recommends reviewing your cyber risk coverage with your agent or COPIC underwriter to clarify what it entails, and to evaluate whether current limits are appropriate for your needs.

- Guide to Privacy and Security of Health Information: **www.HealthIT.gov**
- U.S. Department of Health
  and Human Services—Guidance on Risk Analysis (HIPAA):
  http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/rafinalguidance.html
- Basic information can be obtained from:
  www.hhs.gov/ocr/privacy/hipaa/understanding/srsummary.html
- The U.S. Department of Health and Human Services has created a useful
  "Security Risk Assessment Tool," which can be downloaded at:
  www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool

TELEHEALTH RESOURCES

Resource	Description
Agency for Healthcare Research and Quality (AHRQ) Telehealth	Resources include a mix of tools, research, and listing of funding opportunities; AHRQ offers a sample telehealth consent form that you can download and customize for your needs. www.ahrq.gov/topics/telehealth.html
American Medical Association (AMA) Telehealth Guide	▸ The **AMA Digital Health Implementation Playbook** series offers comprehensive step-by-step guides to implementing digital health solutions, specifically telemedicine, in practice based on insights from across the medical community. Each Playbook offers key steps, best practices and resources to support an efficient and clear path to implementation and scale. ▸ The AMA, in collaboration with Manatt Health, developed a **"Return on Health" framework** to show the value of telehealth programs can increase the overall health and generate positive impact for patients, clinicians, payors and society. ▸ The **Telehealth Immersion Program** is the AMA's newest offering to guide physicians, practices and health systems in optimizing and sustaining telehealth at their organizations. www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide
American Hospital Association—Telehealth	A variety of resources designed for hospitals and their staff. www.aha.org/telehealth
American Telemedicine Association	Resources include a quick-start guide to telehealth, practice guidelines, webinars, news/updates, and other resources. www.americantelemed.org
Center for Connected Health Policy (CCHP)	CCHP tracks telehealth-related laws and regulations across all 50 states and the District of Columbia, as well as at the federal level. Click on a jurisdiction to see all current laws, and pending legislation. www.cchpca.org
CMS Telehealth Resources	Includes access to a list of telehealth services, physician fee schedule, and other resources. www.cms.gov/Medicare/Medicare-General-Information/Telehealth
Federation of State Medical Boards (FSMB) Telehealth Requirements	A PDF document that is updated regularly and offers details on states and their modifying requirements for telehealth (e.g., out-of-state physicians; preexisting provider-patient relationships; audio-only requirements; etc.) www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf
HealthIT.gov Telemedicine and Telehealth Resources	Resources include a telehealth start-up and resource guide. www.healthit.gov/topic/health-it-health-care-settings/telemedicine-and-telehealth
Health Resources & Services Administration (HRSA)	Information on resources including specific telehealth programs overseen by HRSA. www.hrsa.gov/rural-health/telehealth/index.html
HHS Telehealth Resources for Providers	Resources with a focus on getting started with telehealth, planning your telehealth workflow, health equity in telehealth, preparing patients for telehealth, legal considerations, and best practice guides. https://telehealth.hhs.gov/providers/

Interstate Medical Licensure Compact (IMLC)	The IMLC is an agreement among participating U.S. states to work together to significantly streamline the licensing process for physicians who want to practice in multiple states. **www.imlcc.org**
National Committee for Quality Assurance (NCQA) Telehealth Education Resources	A comprehensive guide of educational resources from various health care organizations. **https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/educational-resources/**
National Consortium of Telehealth Resource Centers	Offers resources including links to regional telehealth resource centers. **https://telehealthresourcecenter.org/**
Rural Health Information Hub: Telehealth Use in Rural Care	Specific guidance and resources for rural health facilities and providers. **www.ruralhealthinfo.org/topics/telehealth**

PATIENT EDUCATION RESOURCES

- https://telehealth.hhs.gov/patients/
- https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/c2c/consumer-resources/telehealth-resources
- https://www.medicare.gov/coverage/telehealth

National medical specialty organizations are also great resources for telehealth information that relates to your specific specialty and its unique practice considerations.

Better Medicine • Better Lives

COPIC INSIGHT:
Navigating the Medical Liability Aspects of Telehealth

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7351 E. LOWRY BLVD., STE. 400, DENVER, CO 80230 • 720.858.6000 • 800.421.1834

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