LEGAL CONSIDERATIONS FOR FQHCS: REIMBURSEMENT FOR TELEMEDICINE SERVICES

NEXT CHALLENGE. NEXT LEVEL.
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SOUTH CAROLINA PRIMARY HEALTH CARE ASSOCIATION 2017 STATE POLICY & ISSUES FORUM

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Recent challenges for FQHCs in reimbursement:

- FQHCs are all paid under the Prospective Payment System ("PPS") effective January 1, 2016.
- The base rate for FQHCs is $163.49 (updated annually) (↑ by 1.3416% for new patients including Initial Preventive Physical Exam ("IPPE") and the Annual Wellness Visit (‘AWV’)).
- Subject to the Geographic Adjustment Factor ("GAF") –
  - South Carolina factor for 2017 = 0.959 (also updated annually).
- Adjusted PPS rate for South Carolina ($156.79) = Base rate ($163.49) x GAF ($0.959)
MEDICARE FQHC REIMBURSEMENT

New “G” codes to bill for differing types of visits:

- G0466 New Patient (Not received Medicare covered services from the FQHC within the last three (3) years);
- G0466 Established Patient;
- G0466 Initial Preventive Physical Exam (“IPPE”) or Annual Wellness Visit (“AWV”);
- G0466 New Patient Mental Health;
- G0466 Established Patient Mental Health.

FQHCs set charges for services provided:

- Must be the same for all patients;
- Must maintain a record of charges and services for each visit.
MEDICARE FQHC REIMBURSEMENT

- Coinsurance generally is 20% of the lesser of charges or the FQHC PPS rate.
- Preventive services are exempt from coinsurance which are paid at 100% of the lesser of charges or the FQHC PPS rate.
MEDICARE FQHC REIMBURSEMENT

FQHCs contracting with Medicare Managed Care ("MCO") plans:

- Paid based on PPS rate without comparison to the FQHC’s charges.
- No rate adjustment for coinsurance or preventive services.
- If the MCO rate is less than the PPS rate, then the FQHC will receive a supplemental/wrap around PPS payment (less any cost sharing amounts owed to the beneficiary).
- If the MCO rate is more than the PPS rate, no supplemental payment made.
MEDICARE FQHC REIMBURSEMENT

Rules for billing more than one visit on the same day:

- More than one encounter on the same day for the same illness or injury = one payable visit.

- Two exceptions for billing separately for a same day visit:
  - The patient suffers an injury or illness unrelated to the earlier encounter;
  - If a mental health visit occurs on the same day as the medically related encounter.

- No separate billing if the foregoing happens on a day with an IPPE or AWV.

- Modifier 59 for multiple visits.
“The Secretary shall pay for telehealth services that are furnished via a telecommunications system by a physician (as defined in section 1395x(r) of this title) or a practitioner (described in section 1395u(b)(18)(C) of this title) to an eligible telehealth individual enrolled under this part notwithstanding that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary.” 42 U.S.C.A. § 1395m(m)

Payment may be made for originating site services and distant site services.
MEDICARE REIMBURSEMENT: TELEMEDICINE

‣ Originating site means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs.

‣ Distant site means the site at which the physician or practitioner delivering the service is located at the time the service is provided via a telecommunications system.

‣ Interactive telecommunications means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. (NOT telephone, fax, e-mail).
MEDICARE REIMBURSEMENT: TELEMEDICINE

Originating sites must be:

- Located in a HPSA that is either:
  - Outside of an MSA as of 12/31 of the preceding calendar year; OR
  - Within a rural census tract of an MSA as determined by the Office of Rural Health Policy of HRSA as of 12/31 of the preceding year; OR
  - Located in a county that is not included in an MSA as of 12/31 of the preceding year; OR
  - An entity participating in a Federal Telemedicine Demonstration Project approved by the Secretary of USDHHS as of 12/31/2000 regardless of geographic location.

- Type of facility (Physician office; CAH; RHC; FQHC; Hospital; Hospital or CAH based renal dialysis center; SNF; Community Mental Health Center).

- No “telepresenter” is required as a condition of payment . . . Unless such is medically necessary as determined by the physician or practitioner.

- The patient is under the control of the physician or practitioner at the distant site.
MEDICARE REIMBURSEMENT: TELEMEDICINE

Distant site provider must be:

- Physician;
- Practitioner;
  - Physician Assistant;
  - Nurse Practitioner;
  - Clinical Nurse Specialists;
  - Certified Registered Nurse Anesthetist;
  - Certified Nurse Midwife;
  - Clinical Social Worker;
  - Clinical Psychologist; or
- Registered Dietician or Nutrition Professional.
The originating site facility fee for telehealth services is not an FQHC service. Medicare Claims Processing Manual, Chapter 12, § 190.

- Facility fee for the originating site: $25.40 for 2017

- HCPCS code Q3014 is the only non-FQHC service that is billed using the center bill type and provider number. Id.

- This is billed to the Medicare Administrative Contractor (“MAC”) under Medicare Part B.

- All other non-FQHC services are billed using the base provider’s bill type and billing number/NPI.
MEDICARE REIMBURSEMENT: TELEMEDICINE

- Distant site billing:
  - FQHCs are NOT “authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and may not bill or include the cost of a visit on the cost report.” Medicare Benefit Policy Manual, Chapter 13, § 200.
  - “This includes telehealth services that are furnished by a . . . FQHC practitioner who is employed by or under contract with the . . . FQHC, or a . . . Non-FQHC practitioner furnishing services through a direct or indirect contract.” Id.
  - But, “Independent . . . FQHCs must bill the A/B MAC (B) for all other for all other . . . non-FQHC services.” Medicare Claims Processing Manual, Chapter 12, § 190.
  - Could FQHCs bill Medicare for distant site services?
  - There are sanctions . . .
MEDICARE REIMBURSEMENT: TELEMEDICINE

Sanctions. A distant site practitioner or originating site facility may be subject to the applicable sanctions (Civil Money Penalties / Exclusion / Assessment / Incarceration) provided for in chapter IV, part 402 and chapter V, parts 1001, 1002, and 1003 of this title if he or she does any of the following:

(1) Knowingly and willfully bills or collects for services in violation of the limitation of this section.

(2) Fails to timely correct excess charges by reducing the actual charge billed for the service in an amount that does not exceed the limiting charge for the service or fails to timely refund excess collections.

(3) Fails to submit a claim on a standard form for services provided for which payment is made on a fee schedule basis.

(4) Imposes a charge for completing and submitting the standard claims form. 42 C.F.R. § 414.65(e).
Types of telehealth services available are updated annually.


New services for 2017:

- ESRD-related services CPT Codes 90967-90970;
- Advance care planning CPT Codes 99497-99498; and
- Telehealth consultation HCPCS Codes.

New Place of Service (“POS”) Code for Telehealth is 02 which requires “a description of the location where the health services and health related services are provided or received through telecommunication technology.” See https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9844.pdf.

Claims are submitted using the applicable CPT or HCPCS code for the professional service with the telehealth modifier GT.
MEDICARE REIMBURSEMENT: TELEMEDICINE

See:

- 42 U.S.C.A. § 1395m(m) – Payment for Telehealth Services
- 42 C.F.R. § 410.78 – Telehealth Services
- 42 C.F.R. § 414.65 – Payment for Telehealth Services
FQHCS AND MACRA- DOES IT APPLY?

Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”) called for USDHHS to establish the Medicare Quality Payment Program (“QPP”).

- Continues CMS’ efforts to move from quantity to quality.

- Goals:
  - Improve beneficiary outcomes;
  - Increase adoption of APMs;
  - Improve data sharing;
  - Enhance clinician experience;
  - Maximize participation; and
  - Ensure operations excellence in program implementation.
FQHCS AND MACRA- DOES IT APPLY?

- The QPP will supplant the current Merit-Based Incentive Payment System (“MIPS”) and the incentives under meaningful use.

- QPP has two tracks:
  - Advanced Alternative Payment Models (APMs): CMS Innovation Center model; Medicare Shared Savings Program; Health Care Quality Demonstration Program; or Demonstration required by law: if not in an APM:
  - MIPS

- MIPS requires reporting (minimum of 90 days and as below for full participation) on four weighted performance categories:
  - Quality (60% for 2017 = report on 6 measures);
  - Resource use (cost) (0% for 2017 = no reporting or data submission);
  - Clinical practice improvement (15% in 2017 = varies if PCMH; small or rural practice);
  - EHR technology meaningful use (25% in 2017 = report on 4 measures).
FQHCS AND MACRA- DOES IT APPLY?

But . . .

- Does MACRA affect FQHCs? AND
- Does it matter?
"After consideration of the public comments we received, we are finalizing our proposal that services rendered by an eligible clinician under the RHC or FQHC methodology (AIRS or PPS), will not be subject to the MIPS payments adjustments. However, these eligible clinicians have the option to voluntarily report on applicable measures and activities for MIPS, in which the data received will not be used to assess their performance for the purpose of the MIPS payment adjustment."

BUT, FQHCs bill some services (lab; some radiology and TELEMEDICINE) under Medicare Part B.

Some FQHC providers have received penalty notices for not participating in MIPS.

So, will FQHC employed/contracted physicians some of whose services are billed to Part B be subject to MACRA and its reporting requirements?

If yes, does it matter? . . .
DOES MACRA AFFECT FQHCS?

‣ Yes, it matters.

‣ Physicians subject to QPP will receive payment adjustments:
  ‣ In 2019: + or – 4% based on 2017 performance;
  ‣ In 2020: + or – 5% based on 2018 performance;
  ‣ In 2021: + or – 7% based on 2019 performance; and
  ‣ In 2022: + or – 9% based on 2020 performance.

‣ The good news: There are exceptions:
  ‣ Low volume threshold: If bill $30K or less Part B OR fewer than 100 patients attributed to the group and/or individual.
DOES MACRA AFFECT FQHCS?

If you are not able to reach the low volume threshold, there are (reportedly) fairly easy ways to comply for 2017 under a “pick your pace” option:

- Out of a possible 100 points, the 2017 threshold will be a minimum of 3 points to have a neutral adjustment in 2019.

- Can comply as a “test”:
  - One quality measure;
  - One improvement activity; and
  - Four advancing information measures.
WILL MACRA SURVIVE?

- Likely, yes at least in some form.
- New Secretary Tom Price voted for MACRA in 2015 and MACRA had bipartisan support.
- We haven’t seen what Congress or the new administration will propose for “repeal and replace” of the ACA.
- We will all have to wait and see . . . . .
MEDICAID REIMBURSEMENT FQHCS

- South Carolina Medicaid reimburses FQHC for services.

- Changes in Medicaid payment as well:
  
  - For services on or after July 1, 2016, SCDHHS adopted a new Medicaid rate setting methodology for FQHCs to go from a cost based payment methodology to a prospective payment methodology. See Final Public Notice for FQHC Payment Methodology at https://www.scdhhs.gov/public-notice final-public-notice-fqhc-payment-methodology
  
  - The payment change affects “only” FQHCs that are currently being reimbursed under the Alternate Payment Methodology.

  - Interesting statement . . . At the time, all but one FQHC was under an APM which provided for 100% reimbursement of direct care costs and 30% of overhead based on annual cost reports.
According to SCDHHS “In order to promote provider efficiency, decrease administrative burden and assist in the SCDHHS budgeting process, the SCDHHS proposes to establish prospective payment rates for all contracting FQHCs that are currently being reimbursed under the alternative payment methodology.”

The base year for 2016 was 2014
MEDICAID REIMBURSEMENT: TELEMEDICINE

- South Carolina Medicaid reimburses for telemedicine.

- “Telemedicine is the use of medical information about a patient that is exchanged from one site to another via electronic communications to provide medical care to a patient in circumstances in which face-to-face contact is not necessary.” South Carolina Physicians Provider Manual, Section 2, p. 2-53.

- A physician or “other qualified medical professional” has determined that the medical care can be provided via electronic communication without loss of the quality or efficacy of the care. Id.

- “Electronic communication means the use of interactive telecommunication equipment that typically includes audio and video equipment permitting two-way, real-time interactive communication between the patient and the physician or practitioner at the referring site.” Id.

- The Physicians Provider Manual clarifies that telemedicine is not an expansion of Medicaid-covered services, but is an option for the delivery of care. Id.
MEDICAID REIMBURSEMENT: TELEMEDICINE

- Telemedicine includes consultation, diagnostic, and treatment services. Telemedicine as a service delivery option, in some cases, can provide beneficiaries with increased access to specialists, better continuity of care, and eliminate the hardship of traveling extended distances.

- Consultant site means the site at which the specialty physician or practitioner providing the medical care is located at the time of service provided by telemedicine.

- Providers: Physicians and NPs who are:
  - Licensed in South Carolina;
  - Located in the SC Medical Service Area = SC and within 25 miles of a border state;
  - Currently enrolled as a SC Medicaid provider; and
  - The service is within the Physician or NP’s scope of practice.

MEDICAID REIMBURSEMENT: TELEMEDICINE

- Referring provider: The provider who evaluated the patient, determined the need for a consultation and has arranged the services of the consulting provider.

- Consulting provider: The provider who evaluates the patient via telemedicine (only Physicians and NPs).

- But see new APRN bill filed 2/1/2017 that includes all APRNs providing telehealth at http://www.scstatehouse.gov/sess122_2017-2018/bills/345.htm
MEDICAID REIMBURSEMENT: TELEMEDICINE

- Referring sites (where the patient is located)
  - The office of a physician or practitioner; Hospital (Inpatient and Outpatient); RHC; FQHC; Community Mental Health Centers.

- Covered services include consultation, office visits, individual psychotherapy, pharmacologic management, and psychiatric diagnostic interview examinations and testing, delivered via a telecommunication system.
  - Office or other outpatient visits (CPT codes 99201 – 99215)
  - Inpatient consultation (CPT codes 99251-99255)
  - Psychotherapy, (CPT codes 90832, 90834, and 90837)
  - Psychiatric diagnostic interview examination (CPT code 90791 and 90792)
  - Neurobehavioral status examination (CPT code 96116)
  - Electrocardiogram interpretation and report only (CPT code 93010)
  - Echocardiography (CPT code 93307, 93308, 93320, 93321, and 93325)
MEDICAID REIMBURSEMENT: TELEMEDICINE

- Services not covered include telephone conversations, e-mail messages, video cell phone interactions, facsimile transmissions, and services provided by other allied health professionals.

- A licensed physician and/or nurse practitioner are the only providers of telepsychiatry services.

- A condition of payment is that the telecommunications equipment must:
  - Be HIPAA compliant; and
  - Permit interactive communication between the physician or practitioner at the consulting site and the patient at the referring site.
MEDICAID REIMBURSEMENT: TELEMEDICINE

Coverage Guidelines:

- The beneficiary must be present and participating in the visit.
- The referring provider must provide pertinent medical information and/or records to the consulting provider via a secure transmission.
- Interactive audio and video telecommunication must be used; permitting encrypted communication between the distant site physician or practitioner and the Medicaid beneficiary. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the Telemedicine information transmitted.
MEDICAID REIMBURSEMENT: TELEMEDICINE

Coverage Guidelines continued:

- The telemedicine equipment and transmission speed and image resolution must be technically sufficient to support the service billed. Staff involved in the telemedicine visit must be trained in the use of the telemedicine equipment and competent in its operation.

- An appropriate certified or licensed health care professional at the referring site is required to present (patient site presenter) the beneficiary to the physician or practitioner at the consulting site and remain available as clinically appropriate.

- If the beneficiary is a minor child, a parent and/or guardian must present the minor child for telemedicine service unless otherwise exempted by State or Federal law. The parent and/or guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.

- The beneficiary retains the right to withdraw at any time.
MEDICAID REIMBURSEMENT: TELEMEDICINE

Coverage Guidelines continued:

- All telemedicine activities must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996: Standards for Privacy of individually identifiable Health Information and all other applicable state and federal laws and regulations.

- The beneficiary has access to all transmitted medical information, with the exception of live interactive video, as there is often no stored data in such encounters.

- There will be no dissemination of any beneficiary’s images or information to other entities without written consent from the beneficiary.

- The provider at the distant site must obtain prior approval for service when services require prior approval, based on service type or diagnosis.
MEDICAID REIMBURSEMENT: TELEMEDICINE

Payment:

Referring site: FQHCs are eligible to receive reimbursement for a facility fee for the telemedicine services when operating as the referring site. Claims must be submitted with HCPCS code Q3014 (Telemedicine originating site facility fee). The reimbursement is $14.96 per encounter. When serving as the referring site, the FQHCs cannot bill the encounter T1015 code if these are the only services being rendered.

Consulting site: The FQHCs would bill a T1015 encounter code when operating as the consulting site. Only one encounter code can be billed for a date of service. The FQHC will use the appropriate encounter code for the service along with the "GT" modifier (via interactive audio and video telecommunications system) indicating interactive communication was used.
MEDICAID REIMBURSEMENT: TELEMEDICINE

- Documentation in the medical records must be maintained at the referring and consulting locations to substantiate the service provided. A request for a telemedicine service from a referring provider and the medical necessity for the telemedicine service must be documented in the beneficiary’s medical record. Documentation must indicate the services were rendered via telemedicine. All other Medicaid documentation guidelines apply to the services rendered via telemedicine.
REIMBURSEMENT: PRIVATE

- Varies from payor to payor.
- May require prior approval.
- Review your payor agreement.
As you consider what services to provide, carefully review your payors to determine what telemedicine services are reimbursable.

Keep updated about changes in Medicare/Medicaid reimbursement for telemedicine.

Review your private insurers’ reimbursement requirements for telemedicine services.

Bill only for those specific services that are provided by a qualified provider that are medically necessary.

Code appropriately.
LEGAL CONSIDERATIONS FOR TELEMEDICINE REIMBURSEMENT

Questions?
South Carolina Telemedicine Act

- June 3, 2016 the “South Carolina Telemedicine Act” was approved by the Governor.

- Codifies a number of provisions in prior policy guidance of the SCBoME.
  
  - Establishment of Physician-Patient Relationship as Prerequisite to Prescribing Drugs @
    http://www.llr.state.sc.us/POL/Medical/PDF/Establishment%20of%20Physician-Patient%20Relationship%20as%20Prerequisite%20to%20Prescribing%20Drugs.pdf

  - Telemedicine Advisory Opinion @
    http://www.llr.state.sc.us/POL/Medical/PDF/Telemedicine%20Advisory%20Opinion.pdf
New Definition for Telemedicine

‣ “The *practice of medicine* using electronic communications, information technology, or other means between a licensee in one location and a patient in another location with or without an intervening health care provider.” S.C. Code Ann. § 40-47-20(52).

‣ Tracks language in Telemedicine Advisory Opinion.

‣ The Act applies only to physicians, not other providers.

(A) A licensee who establishes a physician-patient relationship solely via telemedicine as defined in Section 40-47-20(52) must adhere to the same standard of care as a licensee employing more traditional in-person medical care and be evaluated according to the standard of care applicable to the licensee’s area of specialty. A licensee may not establish a physician-patient relationship by telemedicine pursuant to Section 40-47-113(B) for the purpose of prescribing medication when an in-person physical examination is necessary for diagnosis. The failure to conform to the appropriate standard of care is considered unprofessional conduct under Section 40-47-110(B)(9).

Standard of care: The generally recognized practices and procedures that would be exercised by competent practitioners in a practitioner’s field under the same or similar circumstances.

Violation of the standard of care subjects the physician to potential discipline.

Likely will be used in litigation to establish malpractice claims.
SC Telemedicine Act: S.C. Code Ann. 40-47-37(B) Codifies the Requirements for Medical Records

- (B) A physician who establishes a physician-patient relationship solely via telemedicine as defined in Section 40-47-20(52) shall generate and maintain medical records for each patient using such telemedicine services in compliance with any applicable state and federal laws, rules and regulations, including this chapter, the Health Insurance Portability and Accountability Act (HIPAA), and the Health Information Technology for Economic and Clinical Health Act (HITECH). Such records shall be accessible to other practitioners and to the patient in a timely fashion when lawfully requested to do so by a patient or by a lawfully designated representative of a patient.

- Consistent with the Physician Patient Records Act which requires the express written consent of the patient/legal representative to disclose records to another healthcare provider.

- Practice Tip:
  - Create form/links to consents for documentation of the patient’s consent to provide medical records to another provider.
  - Later: Does this apply in the context of when a patient has a primary provider for the specific health issue for which the telemedicine provider is seeing the patient?
Codifies Requirement for Practice Improvement

- (C) In addition to those requirements set forth in Sections (A) and (B) of this Section, a licensee who establishes a physician-patient relationship solely via telemedicine as defined in Section 40-47-20(52) must:
  - (1) Adhere to current standards for practice improvement and monitoring of outcomes and provide reports containing such information upon request of the Board;
  - OK to use same Clinical Quality Measures (CQMs) for health outcomes used to satisfy meaningful use?
a licensee who establishes a physician-patient relationship solely via telemedicine as defined in Section 40-47-20(52) must:

1. Provide an appropriate evaluation prior to diagnosing and/or treating the patient, which need not be done in-person if the licensee employs technology sufficient to accurately diagnose and treat the patient in conformity with the applicable standard of care; provided that evaluations in which a licensee is at a distance from the patient, but a licensed practitioner is able to provide various physical findings that the licensee needs to complete an adequate assessment, is permitted; further provided that a simple questionnaire without an appropriate evaluation is prohibited;

2. Think about what is:
   - An appropriate evaluation?
   - Technology sufficient to accurately diagnose and treat in conformity with the applicable standard of care?
a licensee who establishes a physician-patient relationship solely via telemedicine as defined in Section 40-47-20(52) must:

- (3) Verify the identity and location of the patient and be prepared to inform the patient of the licensee’s name, location, and professional credentials;
  
  Practice Tip: Create forms/links to forms to document the verification process.

- (4) Establish a diagnosis through the use of accepted medical practices, which may include patient history, mental status evaluation, physical examination, and appropriate diagnostic and laboratory testing in conformity with the applicable standard of care;
  
  Practice Tip: Think about how you will document what conforms to the standard of care applicable for your practice.
a licensee who establishes a physician-patient relationship solely via telemedicine as defined in Section 40-47-20(52) must:

- Ensure the availability of appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers, to be distributed to other treating health care providers only with patient consent and in accordance with applicable law and regulation;

Practice Tip:

- Create form/links to forms to document how the patient accesses follow up care.
- Be sure to get the patient’s express written consent to disclose their medical record to other treating providers.
a licensee who establishes a physician-patient relationship solely via telemedicine as defined in Section 40-47-20(52) must:

- (6) Prescribe within a practice setting fully in compliance with this Section 40-47-37 and during an encounter in which threshold information necessary to make an accurate diagnosis has been obtained in a medical history interview conducted by the prescribing licensee; provided, however, that Schedule II and Schedule III prescriptions are not permitted except for those Schedule II and III medications specifically authorized by the Board, which may include, but not be limited to, Schedule II-nonnarcotic and Schedule III-nonnarcotic medications; further provided that licensees prescribing controlled substances by means of telemedicine must comply with all relevant federal and state laws including, but not limited to, participation in the South Carolina Prescription Monitoring Program set forth in Article 15 of Title 44, Chapter 53 of the 1976 Code; further provided, that prescribing of lifestyle medications including, but not limited to, hormone replacement therapies, birth control, or erectile dysfunction drugs are not permitted unless approved by the Board;

- Practice Tip: Be very familiar with the Pain Management Guidelines @ http://www.llr.state.sc.us/POL/Medical/PDF/Joint_Revised_Pain_Management_Guidelines.pdf
a licensee who establishes a physician-patient relationship solely via telemedicine as defined in Section 40-47-20(52) must:

- (7) **Maintain a complete record of the patient’s care** according to prevailing medical record standards that reflects an appropriate evaluation of the patient’s presenting symptoms; provided that **relevant components of the telemedicine interaction be documented as with any other encounter**;

- (8) **Maintain the patient record’s confidentiality and disclose the records to the patient consistent with state and federal law**; provided that licensees practicing telemedicine shall be held to the same standards of professionalism concerning medical records transfer and communication with the primary care provider and medical home as licensees practicing via traditional means; further provided that **if a patient has a primary care provider and a telemedicine provider for the same ailment, then the primary care provider’s medical record and the telemedicine provider’s record constitute one complete medical record**;

**Practice Tip:**

- Be sure to provide the medical record to the patient’s primary provider.

- Does this still require express written consent if the statute states the telemedicine record and the primary provider’s record “constitute one complete medical record”?

- Get consent until clarified.
a licensee who establishes a physician-patient relationship solely via telemedicine as defined in Section 40-47-20(52) must:

- (9) Be licensed to practice medicine in South Carolina; provided, however, licensees need not reside in South Carolina so long as they have a valid, current South Carolina medical license; further provided, that licensees residing in South Carolina who intend to practice medicine via telemedicine to treat or diagnose patients outside of South Carolina must comply with other state licensing boards;

- Practice Tip: Know the law in the state in which you are located.
a licensee who establishes a physician-patient relationship solely via telemedicine as defined in Section 40-47-20(52) must:

- (10) *Discuss with the patient the value of having a primary care medical home* and, if the patient requests, *provide assistance in identifying available options for a primary care medical home.*

Practice Tip: Create a form/link to where documentation of the value of having a medical home and options for a primary care medical home is required.
(D) A licensee, practitioner, or any other person involved in a telemedicine encounter must be trained in the use of the telemedicine equipment and competent in its operation.

This Subsection is not limited to encounters established solely via telemedicine.
(E) Notwithstanding any of the provisions of this Section, the Board shall retain all authority with respect to telemedicine practice as granted in § 40-47-10(I) of this Chapter.

This Subsection is not limited to encounters established solely via telemedicine.
S.C. Code Ann. §40-47-10(I)

(I) In addition to the powers and duties enumerated in Section 40-1-70, the board may:

(1) publish advisory opinions and position statements relating to practice procedures or policies authorized or acquiesced to by any agency, facility, institution, or other organization that employs persons authorized to practice under this chapter to comply with acceptable standards of practice;

(2) develop minimum standards for continued competency of licensees continuing in or returning to practice;

(3) adopt rules governing the proceedings of the board and may promulgate regulations for the practice of medicine and as necessary to carry out the provisions of this chapter;

(4) conduct hearings concerning alleged violations of this chapter;

(5) use minimum standards as a basis for evaluating safe and effective medical practice;
(6) license and renew the authorizations to practice of qualified applicants;

(7) approve temporary licenses, limited licenses, and other authorizations to practice in its discretion as it considers in the public interest;

(8) join organizations that develop and regulate the national medical licensure examinations and promote the improvement of the practice of medicine for the protection of the public;

(9) collect any information the board considers necessary, including social security numbers or alien identification numbers, in order to report disciplinary actions to national databanks of disciplinary information as otherwise required by law;

(10) establish guidelines to assist employers of licensees when errors in practice can be handled through corrective action in the employment setting.
Modifies Section 40-47-113(B)

Notwithstanding Subsection (A), [It is professional misconduct to prescribe w/o 1\textsuperscript{st} establishing a proper physician/patient relationship = personally perform and document a HX/PE, make diagnosis, formulate plan, discuss diagnosis and risks/benefits; ensure follow-up]

a licensee may prescribe for a patient whom the licensee has not personally examined under certain circumstances including, but not limited to, writing admission orders for a newly hospitalized patient, prescribing for a patient of another licensee for whom the prescriber is taking call, prescribing for a patient examined by a licensed APRN, a PA, or another physician extender authorized by law and supervised by the physician, or continuing medication on a short-term basis for a new patient prior to before the patient’s first appointment, or prescribing for a patient for whom the licensee has established a physician-patient relationship by telemedicine so long as the licensee complies with Section 40-47-37 of this Act.
Where do we go next?

- There will be questions on when the Act applies and when it does not:
  - When controlled substances may be prescribed without regard as to how the physician/patient relationship was established.
  - Is there a distinction between when controlled substances NOT for pain control may be ordered via telemedicine (See Telemedicine Advisory Op)?

- How does a physician obtain approval to order controlled substances via telemedicine?