

**MEDICAL BOARD STAFF REPORT**

DATE REPORT ISSUED: July 8, 2014  
ATTENTION: Members, Medical Board of California  
SUBJECT: Federation of State Medical Boards Summary  
STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

REQUESTED ACTION:

This report is intended to provide the Members with an update on the Federation of State Medical Boards (FSMB). No action is needed at this time.

FSMB Update:

For the last several years, former Board Member Hedy Chang has been the Board's liaison with the FSMB. However, Ms. Chang's term on the FSMB has expired. The Board was recently informed by the FSMB Board Chair, Donald H. Polk, D.O., that Jacqueline A. Watson, D.O., MBA, would be replacing Ms. Chang as the Board's liaison. Ms. Watson is the Executive Director of the District of Columbia Board of Medicine. The FSMB will be planning a visit at a future Board meeting.

One of the most significant projects at the FSMB is the development of an Interstate Compact. In 2013, the FSMB House of Delegates passed a resolution directing the FSMB to explore the formation of an Interstate Compact to enhance license portability. The FSMB developed a framework for an Interstate Medical Licensure Compact, which would provide a new licensing option under which qualified physicians seeking to practice in multiple states would be eligible for expedited licensure in all states participating in the Compact. The FSMB, in consultation with State Medical Board representatives, identified eight consensus principles. Those principles are:

- Participation in an interstate compact for medical licensure will be strictly voluntary for both physicians and state boards of medicine.
- Participation in an interstate compact creates another pathway for licensure, but does not otherwise change a state's existing Medical Practice Act.
- The practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and, therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located.
- An interstate compact for medical licensure will establish a mechanism whereby any physician practicing in the state will be known by, and under the jurisdiction of, the state medical board where the practice occurs.
- Regulatory authority will remain with the participating state medical boards, and will not be delegated to any entity that would administer a compact.
- A physician practicing under an interstate compact is bound to comply with the statutes, rules and regulations of each compact state wherein he/she chooses to practice.
- State boards participating in an interstate compact are required to share complaint/investigative information with each other.
- The license to practice can be revoked by any or all of the compact states.

Based upon these principles, the FSMB developed a draft compact, which was sent to the Board in December 2013. The Board provided feedback on the proposed compact. At the April 2014 FSMB Annual Meeting the Interstate Compact was an item of discussion. Based upon feedback

received, the FSMB edited the draft to incorporate some of the issues identified. In May 2014, the FSMB submitted a second draft (**see Attachment A**) for review and comment.

The FSMB has stated that final model legislation for the interstate medical licensure compact will be ready for state legislative consideration beginning in 2015. Under the new proposed system, participating state medical boards would retain their licensing and disciplinary authority, but would agree to share information and processes essential to the licensing and regulation of physicians who practice across state borders. Again, participation in the compact would be voluntary, for both states and physicians.

Based upon Board staff review the most significant concern in the Interstate Compact is the fact that it does not require individuals to be fingerprinted. The Board requires all applicants to be fingerprinted. This requirement assists the Board in two areas. First, it verifies that the information the physician is providing to the Board is accurate. The Board asks all applicants if they have been convicted of a crime. The only way to ensure the response received is accurate is by having an individual fingerprinted. The second reason that fingerprints are necessary, is because if the individual is arrested, the Board is notified via a subsequent arrest report. Therefore, the Board staff believes that in California the applicant would still need to be fingerprinted. Board staff has provided this information to the FSMB.

#### FSMB's Foundation Grants:

As stated at the May 2014 Board Meeting, the FSMB Foundation awarded the Board a \$10,000 grant to provide educational programming on extended-release and long-acting opioid analgesic prescribing to healthcare professionals. The grant is to be used to conduct free live seminars on extended-release and long-acting opioid analgesic prescribing for licensees. By December 31, 2014, the Board must secure a minimum of 250 prescribers to participate in the three-hour program.

Board staff has been working on the specifics of this training, including locating a physician trainer, locating a location and facility, identifying outreach opportunities to advertise for the training, etc. The training will be held in the Los Angeles area on a Friday in September 2014. Once the details have been finalized, the Board will be sending an email out to all physicians encouraging participation, as well as reaching out to physician associations and organizations. Board staff has already been in contact with several organizations who are willing to help promote this event.

If the Board is unable to obtain the necessary prescribers during the training in the Los Angeles area, the Board plans to hold another training session in Northern California either late October or the first week of November. The Board believes this training will very helpful for physicians.

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# **INTERSTATE MEDICAL LICENSURE COMPACT**

(May 5, 2014)

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*The ideas and conclusions set forth in this draft, including the proposed statutory language and any comments or notes, have not been formally endorsed by the Federation of State Medical Boards or its Board of Directors. This draft has been prepared to study the feasibility of an interstate compact, and does not necessarily reflect the views of the Federation of State Medical Boards, the Board of Directors of the Federation of State Medical Boards, or any state medical board or its members.*

**INTERSTATE MEDICAL LICENSURE COMPACT**

**SECTION 1. PURPOSE**

In order to strengthen access to health care and in recognition of the advances in the delivery of health care, the member states of the Interstate Medical Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of state medical boards, ensures the safety of patients, and enhances the portability of a medical license, providing a streamlined process that allows physicians to become licensed in multiple states. The Compact also adopts the prevailing standard for licensure, that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. The Compact creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act. State medical boards that participate in the Compact retain the jurisdiction to impose an adverse action against a license to practice medicine in that state issued to a physician through the procedures in the Compact.

**SECTION 2. DEFINITIONS**

In this compact:

(a) "Bylaws" means those bylaws established by the Interstate Commission pursuant to Section 11 for its governance, or for directing and controlling its actions and conduct.

(b) "Commissioner" means the voting representative appointed by each member board pursuant to Section 11.

(c) "Conviction" means a finding by a court that an individual is guilty of a criminal offense through adjudication, or entry of a plea of guilt or no contest to the charge by the

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1 offender. Evidence of an entry of a conviction of a criminal offense by the trial court shall be  
2 considered final for purposes of disciplinary action by a member board.

3 (d) "Expedited License" means a full and unrestricted medical license granted by a  
4 member state to an eligible physician through the process set forth in the Compact.

5 (e) "Interstate Commission" means the interstate commission created pursuant to Section  
6 11.

7 (f) "License" means authorization by a state for a physician to engage in the practice of  
8 medicine, which would be unlawful without the authorization.

9 (g) "Medical Practice Act" means laws and regulations governing the practice of  
10 allopathic and osteopathic medicine within a member state.

11 (h) "Member Board" means a state agency in a member state that acts in the sovereign  
12 interests of the state by protecting the public through licensure, regulation, and education of  
13 physicians as directed by the state government.

14 (i) "Member State" means a state that has enacted the Compact.

15 (j) "Practice of medicine" means the clinical prevention, diagnosis, or treatment of human  
16 disease, injury, or condition requiring a physician to obtain and maintain a license in compliance  
17 with the Medical Practice Act of a member state.

18 (k) "Physician" means any person who:

19 (1) Is a graduate of

20 (a) a medical school accredited by the Liaison Committee on Medical Education  
21 or the Commission on Osteopathic College Accreditation; or

22 (b) a medical school listed in the International Medical Education Directory or  
23 equivalent, and has

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1 (i) Passed each part of the United States Medical Licensing Examination  
2 (USMLE) within three attempts, or any of its predecessor examinations accepted by a state  
3 medical board as an equivalent examination for licensure purposes, and

4 (ii) Held a full and unrestricted license to practice medicine in any state  
5 for at least the past 5 years;

6 (2) Successfully completed graduate medical education approved by the  
7 Accreditation Council for Graduate Medical Education or the American Osteopathic  
8 Association;

9 (3) Holds specialty certification recognized by the American Board of Medical  
10 Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists;

11 (4) Possesses a full and unrestricted license to engage in the practice of medicine  
12 issued by a member board;

13 (5) Has never been convicted, received adjudication, deferred adjudication,  
14 community supervision, or deferred disposition for any offense by a court of appropriate  
15 jurisdiction;

16 (6) Has never held a license authorizing the practice of medicine subject to  
17 discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action  
18 related to non-payment of fees related to a license;

19 (7) Has never had a controlled substance license or permit suspended or revoked by  
20 a state or the United States Drug Enforcement Administration;

21 (8) Is not under active investigation by a licensing agency or law enforcement  
22 authority in any state, federal, or foreign jurisdiction.

23 (1) "Offense" means a felony, gross misdemeanor, or crime of moral turpitude.

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1 (m) “Rule” means a written statement by the Interstate Commission promulgated  
2 pursuant to Section 12 of the Compact that is of general applicability, implements, interprets, or  
3 prescribes a policy or provision of the Compact, or an organizational, procedural, or practice  
4 requirement of the Interstate Commission, and has the force and effect of statutory law in a  
5 member state, and includes the amendment, repeal, or suspension of an existing rule.

6 (n) “State” means any state, commonwealth, district, or territory of the United States.

7 (o) "State of Principal License" means a member state where a physician holds a license  
8 to practice medicine and which has been designated as such by the physician for purposes of  
9 registration and participation in the Compact.

10

11 **SECTION 3. ELIGIBILITY**

12 (a) A physician must meet the eligibility requirements as defined in Section 2(k) to  
13 receive an expedited license under the terms and provisions of the Compact.

14 (b) A physician who does not meet the requirements of Section 2(k) may obtain a license  
15 to practice medicine in a member state if the individual complies with all laws and requirements,  
16 other than the Compact, relating to the issuance of a license to practice medicine in that state.

17

18 **SECTION 4. DESIGNATION OF STATE OF PRINCIPAL LICENSE**

19 (a) A physician shall designate a member state as the state of principal license for  
20 purposes of registration for expedited licensure through the Compact if the physician possesses a  
21 full and unrestricted license to practice medicine in that state, and the state is:

22 (1) the state of primary residence for the physician, or

23 (2) the state where at least 25% of the practice of medicine occurs, or

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1 (3) the location of the physician's employer, or  
2 (4) if no state qualifies under subsection (1), subsection (2), or subsection (3), the  
3 state designated as state of residence for purpose of federal income tax.

4 (b) A physician may redesignate a member state as state of principal license at any time,  
5 as long as the state meets the requirements in subsection (a).

6 (c) The Interstate Commission is authorized to develop rules to facilitate redesignation of  
7 another member state as the state of principal license.

8

9 **SECTION 5. APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE**

10 (a) A physician seeking licensure through the Compact shall file an application for an  
11 expedited license with the member board of the state selected by the physician as the state of  
12 principal license.

13 (b) Upon receipt of an application for an expedited license, the member board in the state  
14 selected as the state of principal license shall evaluate whether the physician is eligible for  
15 expedited licensure and issue a letter of qualification, verifying or denying the physician's  
16 eligibility, to the Interstate Commission. Static qualifications, which include verification of  
17 medical education, graduate medical education, results of any medical or licensing examination,  
18 and other qualifications as determined by the Interstate Commission through rule, shall not be  
19 subject to additional primary source verification where already primary source verified by the  
20 state of principal licensure. Appeal on the determination of eligibility shall be made to the  
21 member state where the application was filed and shall be subject to the law of that state.

22 (c) Physicians eligible for an expedited license shall complete the registration process  
23 established by the Interstate Commission to receive a license in a member state, including the

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1 payment of any applicable fees.

2 (d) After receiving verification of eligibility under subsection (b) and any fees under  
3 Section 6, a member board shall issue an expedited license to the physician. This license shall  
4 authorize the physician to practice medicine in the issuing state consistent with the Medical  
5 Practice Act and all applicable laws and regulations of the issuing member board and member  
6 state.

7 (e) An expedited license shall be valid for a period consistent with the licensure periods  
8 in the member state and in the same manner as required for other physicians holding a license  
9 within the member state.

10 (f) An expedited license obtained though the Compact shall be terminated if a physician  
11 fails to maintain a license in the state of principal licensure for a non-disciplinary reason, without  
12 redesignation of a new state of principal licensure.

13 (g) The Interstate Commission is authorized to develop rules regarding the application  
14 process and the issuance of an expedited license.

15

16 **SECTION 6. FEES FOR EXPEDITED LICENSURE**

17 (a) A member state issuing an expedited license authorizing the practice of medicine in  
18 that state may impose a fee for a license issued or renewed through the Compact.

19 (b) The Interstate Commission is authorized to develop rules regarding fees for expedited  
20 licenses.

21

22 **SECTION 7. RENEWAL AND CONTINUED PARTICIPATION**

23 (a) A physician seeking to renew an expedited license granted in a member state shall

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1 complete a renewal process with the Interstate Commission if the physician:

2 (1) Maintains a full and unrestricted license in a state of principal license,

3 (2) Has not been convicted, received adjudication, deferred adjudication,  
4 community supervision, or deferred disposition for any offense by a court of appropriate  
5 jurisdiction,

6 (3) Has not had a license authorizing the practice of medicine subject to discipline  
7 by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to  
8 non-payment of fees related to a license,

9 (4) Has not had a controlled substance license or permit suspended or revoked by  
10 a state or the United States Drug Enforcement Administration, and

11 (5) Is not under investigation by a licensing agency or law enforcement authority  
12 in any state, federal, or foreign jurisdiction at the time renewal is sought.

13 (b) Physicians shall comply with all continuing professional development or continuing  
14 medical education requirements in member states where renewal is sought.

15 (c) The Interstate Commission shall collect any renewal fees charged for the renewal of  
16 a license and distribute the fees to the applicable member board.

17 (c) Upon receipt of any renewal fees collected in subsection (b), a member board shall  
18 renew the physician's license.

19 (d) Physician information collected by the Interstate Commission during the renewal  
20 process will be distributed to all member boards.

21 (e) The Interstate Commission is authorized to develop rules to address renewal of  
22 licenses obtained through the Compact.

23  
24 **SECTION 8. COORDINATED INFORMATION SYSTEM**

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1  
2 (a) The Interstate Commission shall establish a database of all physicians licensed, or  
3 who have applied for licensure, under Section 5.

4 (b) Notwithstanding any other provision of law, member boards shall report to the  
5 Interstate Commission any public action or complaints against a physician licensed who has  
6 applied or received an expedited license through the Compact.

7 (c) Member boards shall report disciplinary or investigatory information determined as  
8 necessary and proper by rule of the Interstate Commission.

9 (d) Member boards may report any non-public complaint, disciplinary, or investigatory  
10 information not required by subsection (c) to the Interstate Commission.

11 (e) Member boards shall share complaint or disciplinary information about a physician  
12 upon request of another member board.

13 (f) All information provided to the Interstate Commission or distributed by member  
14 boards shall be confidential, filed under seal, and used only for investigatory or disciplinary  
15 matters.

16 (g) The Interstate Commission is authorized to develop rules for mandated or  
17 discretionary sharing of information by member boards.

18

19 **SECTION 9. JOINT INVESTIGATIONS**

20 (a) Licensure and disciplinary records of physicians are deemed investigative.

21 (b) In addition to the authority granted to a member board by its respective Medical  
22 Practice Act or other applicable state law, a member board may participate with other member  
23 boards in joint investigations of physicians licensed by the member boards.

24 (c) A subpoena issued by a member state shall be enforceable in other member states.

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1 (d) Member boards may share any investigative, litigation, or compliance materials in  
2 furtherance of any joint or individual investigation initiated under the Compact.

3 (e) Any member state may investigate actual or alleged violations of the statutes  
4 authorizing the practice of medicine in any other member state in which a physician holds a  
5 license to practice medicine.

6

7 **SECTION 10. DISCIPLINARY ACTIONS**

8 (a) Any disciplinary action taken by any member board against a physician licensed  
9 through the Compact shall be deemed unprofessional conduct which may be subject to discipline  
10 by other member boards, in addition to any violation of the Medical Practice Act or regulations  
11 in that state.

12 (b) If a license granted to a physician by the member board in the state of principal  
13 license is revoked, surrendered or relinquished in lieu of discipline, or suspended for an  
14 indefinite period of time, all licenses issued to the physician by member boards shall  
15 automatically be placed, without further action necessary by any member board, on the same  
16 status. If the member board in the state of principal license subsequently reinstates the  
17 physician's license, a licensed issued to the physician by any other member board shall remain  
18 encumbered until that respective member board takes action to reinstate the license.

19 (c) If disciplinary action is taken against a physician by a member board not in the state  
20 of principal license, any other member board may deem the action conclusive as to matter of law  
21 and fact decided, and:

22 (i) impose the same or lesser sanction(s) against the physician;

23 (ii) or pursue separate disciplinary action against the physician under its

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1 respective medical practice act, regardless of the action taken in other member states.

2 (d) If a license granted to a physician by a member board is revoked, surrendered or  
3 relinquished in lieu of discipline, or suspended for an indefinite period of time, any license(s)  
4 issued to the physician by any other member board(s) shall be suspended, automatically and  
5 immediately without further action necessary by the other member board(s), for ninety (90) days  
6 upon entry of the order by the disciplining board, to permit the member board(s) to investigate  
7 the basis for the action. A member board may terminate the automatic suspension of the license  
8 it issued prior to the completion of the ninety (90) day suspension period.

9

10 **SECTION 11. INTERSTATE MEDICAL LICENSURE COMPACT**

11 **COMMISSION**

12 (a) The member states hereby create the "Interstate Medical Licensure Compact  
13 Commission".

14 (b) The purpose of the Interstate Commission is the administration of the Interstate  
15 Medical Licensure Compact, which is a discretionary state function.

16 (c) The Interstate Commission shall be a body corporate and joint agency of the member  
17 states and shall have all the responsibilities, powers, and duties set forth in the Compact, and  
18 such additional powers as may be conferred upon it by a subsequent concurrent action of the  
19 respective legislatures of the member states in accordance with the terms of the Compact.

20 (d) The Interstate Commission shall consist of two voting representatives appointed by  
21 each member state who shall serve as Commissioners. In states where allopathic and osteopathic  
22 physicians are regulated by separate member boards, or if the licensing and disciplinary authority  
23 is split between multiple member boards within a member state, the member state shall appoint

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1 one representative from each member board. A Commissioner shall be a(n):

2 (1) Allopathic or osteopathic physician appointed to a member board,

3 (2) Executive director, executive secretary, or similar executive of a member

4 board, or

5 (3) Member of the public appointed to a member board.

6 (e) The Interstate Commission shall meet at least once each calendar year. A portion of  
7 this meeting shall be a business meeting to address such matters as may properly come before the  
8 Commission, including the election of officers. The chairperson may call additional meetings  
9 and shall call for a meeting upon the request of a majority of the member states.

10 (f) The bylaws may provide for meetings of the Interstate Commission to be conducted  
11 by telecommunication or electronic communication.

12 (g) Each Commissioner participating at a meeting of the Interstate Commission is entitled  
13 to one vote. A majority of Commissioners shall constitute a quorum for the transaction of  
14 business, unless a larger quorum is required by the bylaws of the Interstate Commission. A  
15 Commissioner shall not delegate a vote to another Commissioner. In the absence of its  
16 Commissioner, a member state may delegate voting authority for a specified meeting to another  
17 person from that state who shall meet the requirements of subsection (d).

18 (h) The Interstate Commission shall provide public notice of all meetings and all  
19 meetings shall be open to the public. The Interstate Commission may close a meeting, in full or  
20 in portion, where it determines by a two-thirds vote of the Commissioners present that an open  
21 meeting would be likely to:

22 (1) Relate solely to the internal personnel practices and procedures of the  
23 Interstate Commission;

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- 1 (2) Discuss matters specifically exempted from disclosure by federal statute;
- 2 (3) Discuss trade secrets, commercial, or financial information that is privileged
- 3 or confidential;
- 4 (4) Involve accusing a person of a crime, or formally censuring a person;
- 5 (5) Discuss information of a personal nature where disclosure would constitute a
- 6 clearly unwarranted invasion of personal privacy;
- 7 (6) Discuss investigative records compiled for law enforcement purposes; or
- 8 (7) Specifically relate to the participation in a civil action or other legal
- 9 proceeding.

10 (i) The Interstate Commission shall keep minutes which shall fully describe all matters  
11 discussed in a meeting and shall provide a full and accurate summary of actions taken, including  
12 record of any roll call votes.

13 (j) The Interstate Commission shall make its information and official records, to the  
14 extent not otherwise designated in the Compact or by its rules, available to the public for  
15 inspection.

16 (k) The Interstate Commission shall establish an executive committee, which shall  
17 include officers, members, and others as determined by the bylaws. The executive committee  
18 shall have the power to act on behalf of the Interstate Commission, with the exception of  
19 rulemaking, during periods when the Interstate Commission is not in session. The executive  
20 committee shall oversee the administration of the Compact including enforcement and  
21 compliance with the provisions of the Compact, its bylaws and rules, and other such duties as  
22 necessary.

23 (l) The Interstate Commission may establish other committees for governance and

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1 administration of the Compact.

2

3 **SECTION 12. POWERS AND DUTIES OF THE INTERSTATE COMMISSION**

4 The Interstate Commission shall have the duty and power to

5 (a) Oversee and maintain the administration of the Compact;

6 (b) Promulgate rules which shall be binding to the extent and in the manner provided for  
7 in the Compact;

8 (c) Issue, upon the request of a member state or member board, advisory opinions  
9 concerning the meaning or interpretation of the Compact, its bylaws, rules, and actions;

10 (d) Enforce compliance with Compact provisions, the rules promulgated by the Interstate  
11 Commission, and the bylaws, using all necessary and proper means, including but not limited to  
12 the use of judicial process;

13 (e) Establish and appoint committees including, but not limited to, an executive  
14 committee as required by Section 11, which shall have the power to act on behalf of the  
15 Interstate Commission in carrying out its powers and duties;

16 (f) Pay, or provide for the payment of the expenses related to the establishment,  
17 organization, and ongoing activities of the Interstate Commission;

18 (g) Establish and maintain one or more offices;

19 (h) Borrow, accept, hire, or contract for services of personnel;

20 (i) Purchase and maintain insurance and bonds;

21 (j) Employ an executive director who shall have such powers to employ, select or appoint  
22 employees, agents, or consultants, and to determine their qualifications, define their duties, and  
23 fix their compensation;

24 (k) Establish personnel policies and programs relating to conflicts of interest, rates of

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1 compensation, and qualifications of personnel;

2 (l) Accept donations and grants of money, equipment, supplies, materials and services,  
3 and to receive, utilize, and dispose of it in a manner consistent with the conflict of interest  
4 policies established by the Interstate Commission;

5 (m) Lease, purchase, accept contributions or donations of, or otherwise to own, hold,  
6 improve or use, any property, real, personal, or mixed;

7 (n) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any  
8 property, real, personal, or mixed;

9 (o) Establish a budget and make expenditures;

10 (p) Adopt a seal and bylaws governing the management and operation of the Interstate  
11 Commission;

12 (q) Report annually to the legislatures and governors of the member states concerning the  
13 activities of the Interstate Commission during the preceding year. Such reports shall also include  
14 reports of financial audits and any recommendations that may have been adopted by the  
15 Interstate Commission;

16 (r) Coordinate education, training, and public awareness regarding the Compact, its  
17 implementation, and its operation;

18 (s) Maintain records in accordance with the bylaws;

19 (t) Seek and obtain trademarks, copyrights, and patents; and

20 (u) Perform such functions as may be necessary or appropriate to achieve the purposes of  
21 the Compact.

22

23 **SECTION 13. FINANCE POWERS**

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1           (a) The Interstate Commission may levy on and collect an annual assessment from each  
2 member state to cover the cost of the operations and activities of the Interstate Commission and  
3 its staff. The total assessment must be sufficient to cover the annual budget approved each year  
4 for which revenue is not provided by other sources. The aggregate annual assessment amount  
5 shall be allocated upon a formula to be determined by the Interstate Commission, which shall  
6 promulgate a rule binding upon all member states.

7           (b) The Interstate Commission shall not incur obligations of any kind prior to securing  
8 the funds adequate to meet the same.

9           (c) The Interstate Commission shall not pledge the credit of any of the member states,  
10 except by and with the authority of the member state.

11           (d) The Interstate Commission shall be subject to a yearly financial audit conducted by a  
12 certified or licensed public accountant and the report of the audit be included in the annual report  
13 of the Interstate Commission.

14

15           **SECTION 14. ORGANIZATION AND OPERATION OF THE INTERSTATE**  
16 **COMMISSION**

17           (a) The Interstate Commission shall, by a majority of members present and voting, adopt  
18 bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes of the  
19 Compact within twelve (12) months of the first Interstate Commission meeting.

20           (b) The Interstate Commission shall elect or appoint annually from among its members a  
21 chairperson, a vice-chairperson, and a treasurer, each of whom shall have such authority and  
22 duties as may be specified in the bylaws. The chairperson, or in the chairperson's absence or  
23 disability, the vice-chairperson, shall preside at all meetings of the Interstate Commission.

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1 (c) Officers selected in subsection (b) shall serve without compensation or remuneration  
2 from the Interstate Commission.

3 (d) The officers and employees of the Interstate Commission shall be immune from suit  
4 and liability, either personally or in their official capacity, for a claim for damage to or loss of  
5 property or personal injury or other civil liability caused or arising out of or relating to an actual  
6 or alleged act, error, or omission that occurred, or that such person had a reasonable basis for  
7 believing occurred, within the scope of Interstate Commission employment, duties, or  
8 responsibilities; provided that such person shall not be protected from suit or liability for  
9 damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of  
10 such person.

11 (1) The liability of the executive director and employees of the Interstate  
12 Commission or representatives of the Interstate Commission, acting within the scope of such  
13 person's employment or duties for acts, errors, or omissions occurring within such person's state,  
14 may not exceed the limits of liability set forth under the constitution and laws of that state for  
15 state officials, employees, and agents. The Interstate Commission is considered to be an  
16 instrumentality of the states for the purposes of any such action. Nothing in this subsection shall  
17 be construed to protect such person from suit or liability for damage, loss, injury, or liability  
18 caused by the intentional or willful and wanton misconduct of such person.

19 (2) The Interstate Commission shall defend the executive director, its employees,  
20 and subject to the approval of the attorney general or other appropriate legal counsel of the  
21 member state represented by an Interstate Commission representative, shall defend such  
22 Interstate Commission representative in any civil action seeking to impose liability arising out of  
23 an actual or alleged act, error or omission that occurred within the scope of Interstate

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1 Commission employment, duties or responsibilities, or that the defendant had a reasonable basis  
2 for believing occurred within the scope of Interstate Commission employment, duties, or  
3 responsibilities, provided that the actual or alleged act, error, or omission did not result from  
4 intentional or willful and wanton misconduct on the part of such person.

5 (3) To the extent not covered by the state involved, member state, or the Interstate  
6 Commission, the representatives or employees of the Interstate Commission shall be held  
7 harmless in the amount of a settlement or judgment, including attorney’s fees and costs, obtained  
8 against such persons arising out of an actual or alleged act, error, or omission that occurred  
9 within the scope of Interstate Commission employment, duties, or responsibilities, or that such  
10 persons had a reasonable basis for believing occurred within the scope of Interstate Commission  
11 employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission  
12 did not result from intentional or willful and wanton misconduct on the part of such persons.

13

14 **SECTION 15. RULEMAKING FUNCTIONS OF THE INTERSTATE**  
15 **COMMISSION**

16 (a) The Interstate Commission shall promulgate reasonable rules in order to effectively  
17 and efficiently achieve the purposes of the Compact. Notwithstanding the foregoing, in the event  
18 the Interstate Commission exercises its rulemaking authority in a manner that is beyond the  
19 scope of the purposes of the Compact, or the powers granted hereunder, then such an action by  
20 the Interstate Commission shall be invalid and have no force or effect.

21 (b) Rules shall be made pursuant to a rulemaking process that substantially conforms to  
22 the “Model State Administrative Procedure Act” of 2010, and as subsequently amended, as may  
23 be appropriate to the operations of the Interstate Commission.

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1 (c) Not later than thirty (30) days after a rule is promulgated, any person may file a  
2 petition for judicial review of the rule in the United States District Court for the District of  
3 Columbia or the federal district where the Interstate Commission has its principal offices;  
4 provided, that the filing of such a petition shall not stay or otherwise prevent the rule from  
5 becoming effective unless the court finds that the petitioner has a substantial likelihood of  
6 success. The court shall give deference to the actions of the Interstate Commission consistent  
7 with applicable law and shall not find the rule to be unlawful if the rule represents a reasonable  
8 exercise of the authority granted to the Interstate Commission.

9

10 **SECTION 16. OVERSIGHT OF INTERSTATE COMPACT**

11 (a) The executive, legislative, and judicial branches of state government in each member  
12 state shall enforce the Compact and shall take all actions necessary and appropriate to effectuate  
13 the Compact’s purposes and intent. The provisions of the Compact and the rules promulgated  
14 hereunder shall have standing as statutory law but shall not override existing state authority to  
15 regulate the practice of medicine.

16 (b) All courts shall take judicial notice of the Compact and the rules in any judicial or  
17 administrative proceeding in a member state pertaining to the subject matter of the Compact  
18 which may affect the powers, responsibilities or actions of the Interstate Commission.

19 (c) The Interstate Commission shall be entitled to receive all service of process in any  
20 such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure  
21 to provide service of process to the Interstate Commission shall render a judgment or order void  
22 as to the Interstate Commission, the Compact, or promulgated rules.

23

24 **SECTION 17. ENFORCEMENT OF INTERSTATE COMPACT**

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1 (a) The Interstate Commission, in the reasonable exercise of its discretion, shall enforce  
2 the provisions and rules of the Compact.

3 (b) The Interstate Commission may, by majority vote of the Commissioners, initiate legal  
4 action in the United States District Court for the District of Columbia or, at the discretion of the  
5 Interstate Commission, in the federal district where the Interstate Commission has its principal  
6 offices, to enforce compliance with the provisions of the Compact, and its promulgated rules and  
7 bylaws, against a member state in default. The relief sought may include both injunctive relief  
8 and damages. In the event judicial enforcement is necessary, the prevailing party shall be  
9 awarded all costs of such litigation including reasonable attorney’s fees.

10 (c) The remedies herein shall not be the exclusive remedies of the Interstate Commission.  
11 The Interstate Commission may avail itself of any other remedies available under state law or the  
12 regulation of a profession.

13

14 **SECTION 18. DEFAULT PROCEDURES**

15 (a) The grounds for default include, but are not limited to, failure of a member state to  
16 perform such obligations or responsibilities imposed upon it by the Compact, or the rules and  
17 bylaws of the Interstate Commission promulgated under the Compact.

18 (b) If the Interstate Commission determines that a member state has defaulted in the  
19 performance of its obligations or responsibilities under the Compact, or the bylaws or  
20 promulgated rules, the Interstate Commission shall:

21 (1) Provide written notice to the defaulting state and other member states, of the  
22 nature of the default, the means of curing the default, and any action taken by the Interstate  
23 Commission. The Interstate Commission shall specify the conditions by which the defaulting

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1 state must cure its default, and

2 (2) Provide remedial training and specific technical assistance regarding the  
3 default.

4 (c) If the defaulting state fails to cure the default, the defaulting state shall be terminated  
5 from the Compact upon an affirmative vote of a majority of the Commissioners and all rights,  
6 privileges, and benefits conferred by the Compact shall terminate on the effective date of  
7 termination. A cure of the default does not relieve the offending state of obligations or liabilities  
8 incurred during the period of the default.

9 (d) Termination of membership in the Compact shall be imposed only after all other  
10 means of securing compliance have been exhausted. Notice of intent to terminate shall be given  
11 by the Interstate Commission to the governor, the majority and minority leaders of the defaulting  
12 state's legislature, and each of the member states.

13 (e) The Interstate Commission shall establish rules and procedures to address licenses and  
14 physicians that are materially impacted by the termination of a member state, or the withdrawal  
15 of a member state.

16 (f) The member state which has been terminated is responsible for all dues, obligations,  
17 and liabilities incurred through the effective date of termination including obligations, the  
18 performance of which extends beyond the effective date of termination.

19 (g) The Interstate Commission shall not bear any costs relating to any state that has been  
20 found to be in default or which has been terminated from the Compact, unless otherwise  
21 mutually agreed upon in writing between the Interstate Commission and the defaulting state.

22 (h) The defaulting state may appeal the action of the Interstate Commission by  
23 petitioning the United States District Court for the District of Columbia or the federal district

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1 where the Interstate Commission has its principal offices. The prevailing party shall be awarded  
2 all costs of such litigation including reasonable attorney’s fees.

3

4 **SECTION 19. DISPUTE RESOLUTION**

5 (a) The Interstate Commission shall attempt, upon the request of a member state, to  
6 resolve disputes which are subject to the Compact and which may arise among member states or  
7 member boards.

8 (b) The Interstate Commission shall promulgate rules providing for both mediation and  
9 binding dispute resolution as appropriate.

10

11 **SECTION 20. MEMBER STATES, EFFECTIVE DATE AND AMENDMENT**

12 (a) Any state is eligible to become a member state of the Compact.

13 (b) The Compact shall become effective and binding upon legislative enactment of the  
14 Compact into law by no less than seven (7) states. Thereafter, it shall become effective and  
15 binding on a state upon enactment of the Compact into law by that state.

16 (c) The governors of non-member states, or their designees, shall be invited to participate  
17 in the activities of the Interstate Commission on a non-voting basis prior to adoption of the  
18 Compact by all states.

19 (d) The Interstate Commission may propose amendments to the Compact for enactment  
20 by the member states. No amendment shall become effective and binding upon the Interstate  
21 Commission and the member states unless and until it is enacted into law by unanimous consent  
22 of the member states.

23

1           **SECTION 21. WITHDRAWAL**

2           (a) Once effective, the Compact shall continue in force and remain binding upon each  
3 and every member state; provided that a member state may withdraw from the Compact by  
4 specifically repealing the statute which enacted the Compact into law.

5           (b) Withdrawal from the Compact shall be by the enactment of a statute repealing the  
6 same, but shall not take effect until one (1) year after the effective date of such statute and until  
7 written notice of the withdrawal has been given by the withdrawing state to the governor of each  
8 other member state.

9           (c) The withdrawing state shall immediately notify the chairperson of the Interstate  
10 Commission in writing upon the introduction of legislation repealing the Compact in the  
11 withdrawing state.

12           (d) The Interstate Commission shall notify the other member states of the withdrawing  
13 state's intent to withdraw within sixty (60) days of its receipt of notice provided under subsection  
14 (c).

15           (e) The withdrawing state is responsible for all dues, obligations and liabilities incurred  
16 through the effective date of withdrawal, including obligations, the performance of which  
17 extend beyond the effective date of withdrawal.

18           (f) Reinstatement following withdrawal of a member state shall occur upon the  
19 withdrawing state reenacting the compact or upon such later date as determined by the Interstate  
20 Commission.

21           (g) The Interstate Commission is authorized to develop rules to address the impact of the  
22 withdrawal of a member state on licenses granted in other member states to physicians who  
23 designated the withdrawing member state as the state of principal license.

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**SECTION 22. DISSOLUTION**

(a) The Compact shall dissolve effective upon the date of the withdrawal or default of the member state which reduces the membership in the Compact to one (1) member state.

(b) Upon the dissolution of the Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Interstate Commission shall be concluded and surplus funds shall be distributed in accordance with the bylaws.

**SECTION 23. SEVERABILITY AND CONSTRUCTION**

(a) The provisions of the Compact shall be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

(b) The provisions of the Compact shall be liberally construed to effectuate its purposes.

(c) Nothing in the Compact shall be construed to prohibit the applicability of other interstate compacts to which the states are members.

**SECTION 24. BINDING EFFECT OF COMPACT AND OTHER LAWS**

(a) Nothing herein prevents the enforcement of any other law of a member state that is inconsistent with the Compact.

(b) All laws in a member state in conflict with the Compact are superseded to the extent of the conflict.

(c) All lawful actions of the Interstate Commission, including all rules and bylaws promulgated by the Commission, are binding upon the member states.

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1           (d) All agreements between the Interstate Commission and the member states are binding  
2 in accordance with their terms.

3           (e) In the event any provision of the Compact exceeds the constitutional limits imposed  
4 on the legislature of any member state, such provision shall be ineffective to the extent of the  
5 conflict with the constitutional provision in question in that member state.

**Model Policy for the  
Appropriate Use of  
Telemedicine Technologies  
in the Practice of Medicine**

April 2014

## MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

*Report of the State Medical Boards' Appropriate Regulation of  
Telemedicine (SMART) Workgroup*

### INTRODUCTION

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the "Model Guidelines for the Appropriate Use of the Internet in Medical Practice" (HOD 2002)<sup>1</sup> and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards") based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients<sup>2</sup> via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

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<sup>1</sup> *The policy on the Appropriate Use of Telemedicine Technologies In the Practice of Medicine supersedes the Model Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).*

<sup>2</sup> *The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.*

# MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

## Model Guidelines for State Medical Boards' Appropriate Regulation of Telemedicine

### Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider.<sup>3</sup> However, state medical boards, in fulfilling their duty to protect the public, face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the prescribing and dispensing of certain medications.

The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these technologies can enhance medical care by facilitating communication with physicians and their patients or other health care providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice.<sup>4</sup>

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.<sup>5</sup>

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;

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<sup>3</sup> See Center for Telehealth and eHealth Law (Ctel), <http://ctel.org/> (last visited Dec. 17, 2013).

<sup>4</sup> *Id.*

<sup>5</sup> See Cal. Bus. & Prof. Code § 2290.5(d).

## MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

### Section Two. Establishing the Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.<sup>6</sup> The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

### Section Three. Definitions

For the purpose of these guidelines, the following definitions apply:

"Telemedicine" means 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 healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.<sup>7</sup>

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.

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<sup>6</sup> American Medical Association, Council on Ethical and Judicial Affairs, *Fundamental Elements of the Patient-Physician Relationship* (1990), available at <http://www.ama-assn.org/resources/doc/code-medical-ethics/1001a.pdf>.

<sup>7</sup> See *Ctel*.

# MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

## Section Four. Guidelines for the Appropriate Use of Telemedicine Technologies in Medical Practice

The [Name of Board] has adopted the following guidelines for physicians utilizing telemedicine technologies in the delivery of patient care, regardless of an existing physician-patient relationship prior to an encounter:

### Licensure:

A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.<sup>8</sup>

### Establishment of a Physician-Patient Relationship:

Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship consistent with the guidelines identified in Section Two, and, while each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.

### Evaluation and Treatment of the Patient:

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

### Informed Consent:

Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician's credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

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<sup>8</sup> Federation of State Medical Boards, *A Model Act to Regulate the Practice of Medicine Across State Lines (April 1996)*, available at [http://www.fsmb.org/pdf/1996\\_grpol\\_telemedicine.pdf](http://www.fsmb.org/pdf/1996_grpol_telemedicine.pdf).

## MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

### Continuity of Care:

Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient, and subject to the patient's consent, any identified care provider of the patient immediately after the encounter.

### Referrals for Emergency Services:

An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

### Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.

### Privacy and Security of Patient Records & Exchange of Information:

Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information," issued by the Department of Health and Human Services (HHS).<sup>9</sup> Guidance documents are available on the HHS Office for Civil Rights Web site at: [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa).

Written policies and procedures should be maintained at the same standard as traditional face-to-face encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory

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<sup>9</sup> 45 C.F.R. § 160, 164 (2000).

## MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

results must be secure within existing technology (i.e. password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

### Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:

Online services used by physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated physicians;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Online services used by physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the site and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Advertising or promotion of goods or products from which the physician receives direct remuneration, benefits, or incentives (other than the fees for the medical care services) is prohibited. Notwithstanding, online services may provide links to general health information sites to enhance patient education; however, the physician should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, physicians should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of preferred relationships with any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from that pharmacy.

## MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

### Prescribing:

Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by [Name of Board].

Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

### **Section Five. Parity of Professional and Ethical Standards**

Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC). There should be parity of ethical and professional standards applied to all aspects of a physician's practice. A physician's professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies.

## MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

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# MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

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