Policy Statement

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Title:	Telemedicine	POL2021-02
References:	Chapter 18.71B RCW; RCW 18.71.011; RCW 18.71.030(6); chapter 18.71A RCW; RCW 7.70.050(4); RCW 18.71.220; RCW 26.44.056; chapter 70.02 RCW	
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Introduction

The Washington Medical Commission (Commission) endorses the use of telemedicine as a tool that has the potential to increase access, lower costs, and improve the quality of healthcare. The Commission issues this policy statement to provide guidance to allopathic physicians and physician assistants (practitioners) who use telemedicine to provide medical services to Washington patients. This policy specifies the conditions under which a license is needed to use telemedicine to treat a patient in Washington and delineates best practices when using telemedicine to ensure that patients receive safe and appropriate care.

In 2014, the Commission issued Guidelines for the Appropriate Use of Telemedicine (MD2014-03), establishing general practice standards for practitioners and initiating a patient-practitioner relationship using telemedicine. In 2018, the Commission issued a policy on Telemedicine and Continuity of Care (POL2018-01). This policy supersedes both the 2014 guidelines and the 2018 policy.

In 2017, Washington joined the Interstate Medical Licensure Compact (compact). The compact, now in place in a majority of states, is intended to facilitate licensure for physicians who practice in multiple states, allowing patients in underserved areas to more easily connect with medical experts through telemedicine technologies.[1]

Policy

Definition of Telemedicine

For the purposes of this policy, the Commission defines telemedicine as a mode of delivering healthcare services using telecommunications technologies by a practitioner to a patient or to another health care provider at a different physical location than the practitioner.

[1] Chapter 18.71B RCW. For information on the compact, see http://www.imlcc.org/

Telemedicine includes real-time interactive services, store-and-forward technologies, and remote monitoring.

Store-and-forward technology is the asynchronous or non-simultaneous transmission of a patient's medical information from an originating site to the health care provider at a distant site that results in examination, medical diagnosis, and treatment of the patient. Remote monitoring involves the use of digital technology to collect health data from a patient in one location and electronically transmit that information securely to a health care provider in another location for evaluation and treatment decisions.

Licensure

The Commission deems the practice of medicine[2] to take place at the location of the patient at the time of the encounter.[3] Therefore, with a few exceptions detailed below, a practitioner engaging in the practice of medicine with a patient located in Washington must hold an active license to practice medicine in Washington. A practitioner licensed in Washington need not reside in Washington to use telemedicine to treat a patient in Washington. A practitioner licensed in Washington who wishes to treat a patient in another state will likely need a license to practice medicine in that state. The practitioner should contact the other state's medical board to find out the requirements for treating patients in that state.

The Commission recognizes several exceptions to the general rule that a practitioner is required to have a license when treating a patient in Washington. The legislature created a specific exemption to the licensure requirement for telemedicine practitioner-to practitioner consultations. The consultation exemption permits a practitioner licensed in another state in which her or she resides to use telemedicine or other means to consult with a Washington-licensed practitioner who remains responsible for diagnosing and treating the patient in Washington.[4].

Although this exemption does not apply to direct physician-to-patient consultations, the Commission understands that there are some situations in which a patient in Washington communicates with practitioners licensed in other states, but that communication does not constitute the practice of medicine. Some examples are specialty assessment or consultation such as a cancer center or a second opinion consultation after a review of medical records. In these cases, the practitioner in the distant state does not need a license to practice medicine in Washington. Once the practitioner agrees to advise or treat the patient, the patient must travel to the state where the practitioner resides, or the practitioner must obtain a license to practice medicine in Washington.

Another common situation that is not specifically addressed by a statutory exemption is when a patient with an established relationship with a practitioner licensed in another state crosses the border into Washington and requires medical care. In some cases, permitting the physician in the patient's home state to provide temporary continuous care is in the patient's best interest. This can arise in several common scenarios.

[2] The practice of medicine is defined in RCW 18.71.011 .
[3] RCW 18.71B.010.
[4] RCW 18.71.030(6)

In the first scenario, a patient with an established relationship with a practitioner in the patient's home state travels to Washington for a limited time (e.g., vacation, business, or education) and requires medical care. The patient's out-of-state practitioner may be the best person to provide care via telemedicine while the patient is temporarily in Washington. If the practitioner knows that the patient will be residing in Washington for an extended period, the practitioner should develop a plan for emergent treatment agreed to by the patient. This may include a referral to a hospital or to a local specialist who can step in and assist in the case of devolving medical or mental status.

In the second scenario, a patient who is receiving treatment for a condition by a practitioner in a distant state moves to Washington and requires immediate medical care for that condition but has not yet established a relationship with a Washington practitioner. For example, a patient receiving psychiatric care and medication management from a psychiatrist in her former state may have difficulty finding a psychiatrist in Washington. Temporary care via telemedicine by the patient's established psychiatrist may be in the patient's best interest until the patient can find a Washington-licensed practitioner to take over the care.

In the third scenario, a Washington resident travels to a distant state to obtain specialty care at a major medical center, then returns home to Washington. The patient may prefer to directly consult via telemedicine with the specialists who provided treatment to the patient in the distant state. Requiring the patient to travel back to the major medical center to receive follow up care could impose an unreasonable hardship on the patient. Permitting the practitioner at the major medical center to provide follow up care via telemedicine is the most optimal treatment plan for the patient.

In each of these cases, the patient needs are best served by having the practitioner who knows the patient and has access to the patient's medical records provide continuous or follow up care to the patient. So long as the out-of-state practitioner provides temporary continuity of care to the patient, the practitioner would not require a Washington license.

Standard of Care

The Commission will hold a practitioner who uses telemedicine to the same standard of care and professional ethics as a practitioner using a traditional in-person encounter with a patient. The failure to follow the appropriate standard of care or professional ethics while using telemedicine may subject the practitioner to discipline by the Commission.

The Commission offers the following guidance to practitioners providing medical services using telemedicine:

Scope of practice

A practitioner who uses telemedicine should ensure that the services provided are consistent with the practitioner's scope of practice, including the practitioner's education, training, experience, and ability.

Identification of patient and practitioner

A practitioner who uses telemedicine should verify the identity of the patient and ensure that the patient can verify the identity, licensure status, and credentials of all health care providers who participate in the telemedicine encounter.

Establishing the Practitioner-patient relationship

A practitioner who uses telemedicine must establish a valid practitioner-patient relationship with the person who receives telemedicine services. The relationship is established when the practitioner agrees to undertake diagnosis or treatment of the patient and the patient agrees that the practitioner will diagnose or treat the patient. A valid practitioner-patient relationship may be established through telemedicine if the standard of care does not require an in-person encounter.

Medical history and physical examination.

Prior to providing treatment, including issuing prescriptions, a practitioner who uses telemedicine should interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. A practitioner may not delegate an appropriate history and physical examination to an unlicensed person or to a licensed individual for whom that function would be out of the scope of the license.

Once a practitioner has obtained a relevant medical history and performed a physical examination, it is within the practitioner's judgment to determine whether it is medically necessary to obtain a history or perform a physical examination at subsequent encounters. The technology used in a telemedicine encounter must be sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person by the practitioner. A static on-line questionnaire does not constitute an acceptable medical interview for the provision of treatment, including issuance of prescriptions, by a practitioner.

Appropriateness of telemedicine

Only the treating practitioner is empowered to make the decision to use telemedicine with a given patient. A practitioner should consider the patient's health status, specific health care needs, and specific circumstances, and use telemedicine only if the risks do not outweigh the potential benefits and it is in the patient's best interest. If a practitioner determines that the use of telemedicine is not appropriate, the practitioner should advise the patient to seek in-person care.

Informed consent

A practitioner who uses telemedicine should ensure that the patient provides appropriate informed consent, whether oral or written, for the medical services provided, A practitioner need not obtain informed consent in an emergency situation or in other situations recognized by Washington law. [5]

[5] Some examples of exceptions to the requirement to provide informed consent are the emergency exception, RCW 7.70.050(4), RCW 18.71.220; medical holds for minors, RCW 26.44.056; and the therapeutic privilege

Coordination of care

When medically appropriate, a practitioner who uses telemedicine should make referrals to the patient for in-person services can be delivered in coordination with the telemedicine services. The practitioner should provide a copy of the medical record to other treating practitioners and to the patient upon request.

Follow-up care

A practitioner who uses telemedicine should have access to, or adequate knowledge of, the nature and availability of local medical resources, including emergency services, to provide appropriate follow-up care to the patient following a telemedicine encounter.

Medical records

A practitioner who uses telemedicine should maintain complete, accurate and timely medical records for the patient when appropriate, including all patient-related electronic communications and instructions obtained or produced in connection with the patient visit. The records must be made available to the patient upon request.

Privacy and security

A practitioner who uses telemedicine should ensure that all telemedicine encounters comply with the privacy and security measures in the Washington Uniform Health Care Information Act, chapter 70.02 RCW, and of the federal health insurance portability and accountability act[6] to ensure that all patient communications and records are secure and remain confidential.

Mobile medical technology

The federal food and drug administration (FDA) regulates the safety and efficacy of medical devices, including mobile medical applications that meet the definition of "device" under the FDA Act, particularly apps that pose a higher risk if they do not work as intended.

A practitioner who uses a mobile medical technology application that meets the definition of a device under the federal food and drug act, or relies upon such technology, should ensure the application has received approval by the federal food and drug administration or is in compliance with applicable federal law.[7]

Those applications used by a physician or patient that do not have the data to support their claims may be investigated by the consumer protection division of the Federal Trade Commission (FTC). If the Commission receives complaints about such apps or devices that are deemed outside its jurisdiction, the Commission will advise the complainant to contact the FDA or the FTC as appropriate.

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recognized in *Canterbury v. Spence,* 464 F.2d 772 (D.C. Cir. 1972, *cert. denied,* 409 U.S. 1064 (1972); *Holt v. Nelson,* 11 Wn. App. 230, 523 P.2d 211 (1974), *rev. denied,* 84 Wn. 2d 1008, 523 P.2d 211 (1974).

[6] Also known as the HIPAA Privacy Rule, 45 CFR Part 160, subparts A and E or Part 164.

[7] See https://www.fda.gov/medical-devices/digital-health-center-excellence/device-software-functions-including-mobile-medical-applications

Artificial intelligence

A practitioner who uses artificial intelligence (AI) tools as part of telemedicine to diagnose or treat a patient in Washington should:

(a) Understand that use of an AI tool and acceptance of suggested diagnosis or related treatment plan is at the discretion of the treating practitioner;

(b) Understand the limitations of using an AI tool, including the potential for bias against populations that are not adequately represented in testing the tool.

A practitioner who uses AI should complete a self-directed CME (category II-V) on bias and underrepresented populations in health care technology applications such as AI.