

In August, the Texas Medical Board adopted amendments to its rules for physicians who are involved in telemedicine. Those rules went into effect in October. When I saw a notice about their adoption, I asked for clarification. Finally, the Board has posted the [FAQs](#) (frequently asked questions) about telemedicine in Texas, and I think the Board (and its staff) has done an excellent job, with ONE exception. I'll get to that, but first let's look at the really good parts of the amended rules.

Texas is one of the few states to define telemedicine for its physician licensees. The Board identified two models – an established medical site like a hospital or a clinic that “has the required medical professionals and equipment” and at home. Initially, I thought the “at home” model was more like RPM (remote patient monitoring). But, the Board defines it as patients accessing healthcare via “video conferencing with a live feed.”

For the established medical sites, the Board envisions “patient site presenters” to assist the remote practitioner. The rules require “sufficient diagnostic equipment” at these sites. There is one exception to the presence of a presenter: mental health treatment. But if a patient could be a danger to him- or herself or others, a presenter would be required.

The established medical site is not limited to a hospital or clinic. The rules permit telemedicine visits to occur from a nurse's station in a school, a volunteer fire department station, an EMS station, a residential or institutional care facility – even a pharmacy. There are some key criteria that must be followed. The patient presenter must be a licensed or certified healthcare professional – a nurse, EMT or pharmacist at minimum. They must have “sufficient technology” and the medical equipment to do an adequate physical evaluation. And the visit must originate from a location that accommodates patient privacy.

For “at home” treatment, patients must have already established a doctor-patient relationship with the physician or PA with whom they have a telemedicine visit. This means, the patient must have been seen in person at the office and a diagnosis was made and documented. This then allows a patient to receive follow-up care for the pre-existing condition via telemedicine in the home. For new symptoms that appear unrelated to the pre-existing condition, a doctor or PA can treat a patient telemetrically for up to 72 hours, as long as the patient is told to see a physician in person within 72 hours if the symptoms do not resolve. Additionally, providers may not continue telemedicine medical services for new symptoms to a patient who is NOT seen within 72 hours. The rule does have some wiggle room for a patient with minor symptoms. In this case, a provider may prescribe a course of treatment that runs longer than 72 hours. Many antibiotics, for instance, have a 10-day course, and some allergy medications have a 30-day course. But, the Board rule warns doctors to stay within the standard of care and not abuse this loophole. It is not intended for doctors to write ongoing prescriptions for new diagnoses.

For definition purposes, a private home is NOT an established medical site, but hospice facilities and nursing homes are not considered private homes, so they may meet the requirements for an established medical site (with the appropriate personnel, technology

and equipment). In our legalistic and litigious society, as well as for the intellectually challenged, the Board had to spell out what it meant by a “face-to-face visit.” The provider and patient have to be at the same physical location or the patient must be at an established medical site.

Here are the hard parts of the rule: What doctors may not do.

1. They can't conduct a telemedicine visit at a patient's home or other non-established medical site WITHOUT a prior face-to-face initial consultation, unless another physician has evaluated the patient in-person and refers the patient to them.
2. They can't provide ongoing medical treatment for a new chronic condition to a patient who has established a doctor-patient relationship for some other medical problem, unless they conduct a “timely in-person evaluation after the diagnosis of the new condition.”
3. They can't prescribe scheduled drugs (i.e., narcotics) for treatment of chronic pain for telemedicine patients.

Each patient who receives telemedicine treatment (again, this refers to video-conferencing visits) at home must see the treating physician for an in-person evaluation AT LEAST ONCE A YEAR.

At the beginning, I noted that there was one problem area that the Texas Board may have created for its licensed physicians. It equates SKYPE with “similar forms of web videoconferencing” and allows it. A lot of people use SKYPE without the knowledge that SKYPE video conversations are not encrypted. It's free and easy to use, but it is a HIPAA violation waiting to happen. Individual practitioners may endorse SKYPE, but no physician group that I know recommends the use of SKYPE. In fact, the physician members of the American Telemedicine Association's Pediatric Special Interest Group are adamant about not using SKYPE for this very reason. Had I been involved in writing this part of the rule, I would have specified a minimum of 128-bit encryption for any video-conferencing hardware codec or software client. And most serious video-conferencing products already meet or beat that standard