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Concerns About Telehealth and Telemedicine Across State Lines in a Post-Pandemic World

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The COVID-19 pandemic created a paradigm shift in the world of medicine with the increased use of telehealth and telemedicine to meet the challenge of expanding the delivery methods patients used to access health care. While technological developments allowed telehealth providers to virtually travel across state lines to meet the needs of their quarantined patients at the push of a button, navigating the web of everchanging state and federal licensing laws has not been as simple. Consequently, telehealth providers must monitor developments in federal and state laws, regulations, and policies to not only capitalize on telehealth opportunities and consistently maintain the quality of health care, but also to ensure compliance with federal and state laws to avoid sanctions, such as the unlicensed practice of medicine, that may also have a ripple effect on hospital staffing and clinical privileges.

Telehealth and Telemedicine Crossing State Lines

Although often used interchangeably, telehealth is the use of digital technologies to access a broad range of health care services outside the traditional, in-person medical settings, and telemedicine often refers to the delivery of medical, diagnostic, and treatment-related services usually by doctors. Stated differently, while telehealth also includes non-clinical health care services, telemedicine refers to remote clinical services. The state where the health care practitioner is located is called the "Home State" or "originating site" and the state where the patient is located is known as the "Remote State" or "distant site."

In addition to facilitating the monitoring of local patients during the pandemic, the continued advancement of telemedicine technology offered health care practitioners opportunities to practice medicine across state lines when, because of quarantine requirements, the patient was in a different state. As telemedicine activities became recognized as a way to practice medicine, those practicing through telehealth were forced to consider the interplay of state licensing laws with practicing medicine across state borders. These laws were relaxed by the federal government, and every state, to ease the interstate telehealth delivery during the pandemic. However, since the President declared an end to the Public Health Emergency on May 11, 2023, so too ended the relaxation or waiver of various regulatory requirements.

The Licensed Practice of Medicine

The Tenth Amendment of the U. S. Constitution grants each state the power to control medical licensure. Without exception, every state accepts the practice of medicine as a regulated profession that requires a license. As such, when a health care practitioner provides medical advice via an online, telemedicine platform to a patient residing in a Remote State, the laws of the Remote State govern. As a consequence of individual state sovereignty, there is no uniform approach to licensing. Therefore, to treat a patient in a Remote State, the health care practitioner must have a license to practice in that state and will be subject to the laws governing that Remote State.

Each state's Medical Board is charged with the responsibility and obligation to protect the public by maintaining the highest levels of quality care. This starts by ensuring that applicants for licensure have received the proper education and training prior to practicing medicine within the state and ends with monitoring and evaluating whether conduct warrants modification, suspension, or revocation. To the extent a health care practitioner treats a patient in a Remote State where the health care practitioner is not licensed, at a minimum, the health care practitioner could potentially become the subject of a disciplinary action within the Remote State, if not prosecuted for the unauthorized practice of medicine.

To prevent licensure from being a significant roadblock to telemedicine, the Federation of State Medical Boards developed the Interstate Medical Licensure Compact (IMLC) to qualify health care practitioners to practice medicine across state lines as long as they meet certain eligibility requirements. The IMLC streamlined the process to make it easier for health care practitioners to treat patients in Remote States. By creating a fast-track option with only one application to fill out, the health care practitioner can receive licenses from multiple states included in the IMLC and be able to fully practice medicine in whichever Remote State they obtained a medical license from. Nonetheless, the health care practitioner remains subject to each Remote State's medical licensing laws as the IMLC will not supersede any state's law. Currently, 32 states, the District of Columbia, and Guam have entered the IMLC.[1]

When and Why Hospitals Should Query the National Practitioners Data Bank

Given the evolution of telehealth services and telemedicine during these unprecedented times, health care practitioners needed to develop an understanding of how telemedicine is regulated nationally to avoid issues surrounding the unlicensed practice of medicine. Any licensing issues resulting in modification, suspension, or revocation of a health care practitioner's license as a result of practicing telemedicine in a Remote State can affect the health care practitioner's medical license or hospital staff privileges in the same way it would for discipline arising from practicing only in the Home State. Both initial and renewal applications for privileges typically include questions concerning licensure such as dates related to status and any disciplinary actions imposed.

Therefore, with health care practitioners becoming increasingly subject to the licensing requirements of Remote States, hospitals should be cognizant of their continued obligations to query the National Practitioner Data Bank (NPDB) concerning physicians applying for medical staff privileges or for reappointments. The NPDB was established by the Health Care Quality Improvement Act of 1986 (HCQIA). The NPDB is a means of accumulating and disseminating information related to adverse peer review actions that impact clinical privileges. Adverse actions include reducing, restricting, suspending, revoking, or denying the clinical privileges of a physician or dentist. The creation of the NPDB and its reporting requirements allowed a centralized means of ensuring that hospitals and state medical boards receive critical and reliable information about physicians employed by the hospital, admitted to the medical staff, or granted clinical privileges.

Enacted to encourage good faith peer review activities in furtherance of protecting patients and to improve the quality of health care, HCQIA has three provisions: (1) immunities from money damages for those involved in peer review activities; (2) reporting requirements

relating to physicians' competence and conduct; and (3) responding to queries for information on physicians applying for medical staff appointment or clinical privileges.

Telemedicine's licensing issues could implicate the third provision of the HCQIA requiring hospitals to query the NPDB when a physician initially applies for medical staff appointment or for clinical privileges. Hospitals have a continuing obligation under the HCQIA to query their physicians every two years. In exchange for reporting, hospitals are provided civil immunity from damages in lawsuits related to peer review actions. Failure to query as required by the HCQIA will charge the hospital with knowledge of information including malpractice payments and adverse licensure or credentialing actions reported to the NPDB relating to any of its applicants for appointment and/or reappointment. Imputing this knowledge exposes the hospital to negligent credentialing liability; and as a related consequence of a failure to report information to the NPDB, the loss of any immunities available under the HCQIA for a three-year period.

Conclusion

Hospitals have a continuing obligation to monitor their medical staff members and are required to take certain actions to protect patients from substandard care. While modification, suspension, or revocation of one's medical license could seem like a heavy-handed response to practicing telemedicine in a Remote State, given that the President declared an end to the Public Health Emergency, hospitals should be aware of potential licensing issues that may begin to surface. Hospitals can protect themselves by running timely queries as required by the HCQIA not only to ensure the best quality of care is given by their medical staff, but also to ensure that they do not increase their exposure to civil liability for failing to do so.

About the Author

Ms. Carroll concentrates her practice in litigation, with an emphasis on representing hospitals in medical staffing and peer review disciplinary matters arising out of issues related to quality care and patient safety. She has represented hospitals, physicians, physician practices, and pharmaceutical companies in matters related to restrictive covenants, breach of contract, violations of due process and fundamental fairness, defamation and trade libel claims, as well as matters related to professional licensure and credentialing. Ms. Carroll's work also includes handling anti-competitive claims alleging violations of New Jersey's Anti-Trust Act, the Sherman Anti-Trust Act, and the Lanham Act, in addition to employment claims, including violations of the New Jersey Law Against Discrimination (NJLAD) and the Conscientious Employee Protection Act (CEPA), in state court, federal court, and in arbitrations.

[1] These states include: Washington, Idaho, Montana, North Dakota, South Dakota, Minnesota, Wisconsin, Michigan, Wyoming, Nebraska, Kansas, Oklahoma, Texas, Louisiana, Iowa, Nebraska, Ohio, Kentucky, West Virginia, New Hampshire, Maine, New Jersey, Delaware, Maryland, Georgia, Alabama, Mississippi, Colorado, Nevada, Utah, Arizona, and Indiana. *See* https://www.imlcc.org/participating-states/.