



## MEMORANDUM

<b>DATE</b>	October 29, 2013
<b>TO</b>	Multidisciplinary Advisory Committee
<b>FROM</b>	Sue Geranen Executive Officer DCA/Veterinary Medical Board
<b>SUBJECT</b>	<b>Review and Consider Telemedicine</b>

**Background:**

This issue of telemedicine was raised by UC Davis at a previous Board meeting and was referred to the Board's Strategic Planning meeting held in October 2011. The result of that meeting was to refer the issue to the MDC for further discussion and public input.

**Issue**

The MDC is in the process of gathering information and has invited UCD, Western University, and CVMA to provide information to the MDC for further discussion.

**Action Requested:**

Discussion and consideration of taking action.

## **Telemedicine Issues**

(A partial list compiled by Jon Klingborg, DVM)

- 1) When is Telemedicine Consultative and when is it Primary Care?
- 2) Does the technology comply with FDA standards?
- 3) Can ongoing care, such as dialysis, be managed by telemedicine? Is there an adequate VCPR?  
  
How about Nutrition, pharmacy, Rx writing, etc.?
- 4) Can telemedicine be used to direct care by RVTs (is it direct or indirect supervision?)
- 5) What will the license requirements be for using telemedicine? Will University employees be exempt from requirements or would there be a restriction to those licensed in California?
- 6) What sort of informed consent would be necessary for clients whose pets are treated via telemedicine?
- 7) Maintaining digital security, confidentiality, and privacy. How is this accomplished?  
  
Complying with FDA standards for this type of technology?
- 8) Tele-education and its role.



**UCDAVIS**  
**VETERINARY MEDICINE**

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18 July, 2011

**To:** California Veterinary Medical Board  
**From:** University of California School of Veterinary Medicine  
**Subject:** Request to review the Veterinarian-Client-Patient Relationship relative to the implementation of telemedicine for the delivery of veterinary services

Dear Members of the Board:

As part of its Clinical Services and mandate to the State of California, the University of California School of Veterinary Medicine (SVM) is a resource for medical/surgical consultation and state-of-the-art specialty expertise to veterinarians, animal owners, and animals throughout the State. Telemedicine is used widely in human medicine and has proven to be indispensable for the extension of specialty expertise and clinical services to remote areas where such services are not readily available. The SVM recognizes that telemedicine represents a new medical frontier that portends an important tool to extend the deliverable expertise, service mission, and the teaching and research mandates of the SVM. The SVM also recognizes this technology needs proper stewardship for its development and implementation in the profession.

The current Veterinarian-Client-Patient Relationship provision of the California Veterinary Practice Act (sec. 2032.1) prohibits veterinarians from providing consultative services, rendering any treatment, or ordering/administering any drug or appliance directly via telemedicine due to the requirement: "The veterinarian has sufficient knowledge of the animal(s) to initiate at least a general or preliminary diagnosis of the medical condition of the animal(s). This means that the veterinarian has recently seen and is personally acquainted with the care of the animal(s) by virtue of an examination of the animal or by medically appropriate and timely visits to the premises where the animals are kept, and..."

Current statutes would also prohibit a consulting veterinarian from using telemedicine technologies to provide "direct supervision". As currently defined by the Animal Health Care Tasks Definitions (sec. 2034): "'Direct Supervision' means: (1) the supervisor is physically present at the location where

animal health care jobs tasks are to be performed and is quickly and easily available; and (2) the animal has been examined by a veterinarian at such time as good veterinary medical practice requires consistent with the particular delegated animal health care job task."

It is the position of the SVM that given the current state-of-the-art and technology, a veterinarian, when medically appropriate, can obtain "sufficient knowledge" about an animal(s) through a comprehensive telemedicine veterinary visit to constitute as effective a Veterinary-Client-Patient relationship as would be constituted with a "personal" relationship. This relationship would be predicated by: (1) direct (in real time) video/audio consultation with the consulting veterinarian, animal owner, and/or animal health caregiver, (2) video/audio evaluation of the animal(s) and animal(s) premises, and (3) digital transfer of all medical records, laboratory evaluations, imaging, pathology, and physiological patient monitoring. Such a telemedicine evaluation would provide the consulting veterinarian "sufficient knowledge" to render a diagnosis, establish a treatment plan, prescribe appropriate drugs, medicine, appliances, or applications of treatments, and "sufficient knowledge" to supervise health care tasks. That is to say, when medically appropriate, the same level of care is rendered via telemedicine consultations such that a personal relationship is established and an examination is conducted, but using a different modality.

Pursuant to the development and use of telemedicine technologies to provide veterinary medical consultations, the School of Veterinary Medicine request the Veterinary Medical Board to review the appropriateness and extend the exemption provided under Section 4830 of the California Veterinary Medicine Practice Act to permit a veterinarians employed by the University of California while engaged in the performance of duties in connection with the School of Veterinary Medicine, to establish a Veterinary-Client-Patient Relationship by telemedicine technologies when remote and distant constraints do not permit a personal and direct (face-to-face) physical relationship.

Respectfully submitted,

Larry D. Cowgill, DVM, PhD  
Matt Mellema, DVM, PhD  
Frank LaBonte, MBA, FACHE, Hospital Administrator  
John R. Pascoe, DVM PhD, Interim Dean

## Supplemental Background and Discussion Points:

Please consider these current examples illustrating how telemedicine is a direct extension of veterinary practices that are well established and ongoing in California and at the VMTH:

(1) For consideration--is the sending a digital image of a skin lesion to a dermatologist fundamentally different than sending a biopsy specimen to a pathologist for interpretation?

- One could argue any difference is semantic at best. The pathologist is making a diagnosis based on largely visual data and has no VCPR. The pathologist is acting solely in a consultant role. By the most conservative interpretation of the act, pathologists should have to come to each practice and meet the client, examine the patient, etc... before rendering any diagnosis.

(2) Same conceptual framework could be applied to radiology and other supportive specialties. Teleradiology is no different than sending films to a radiologist for interpretation which is a standard of care in veterinary practice.

- With a strict interpretation, is the radiologist violating the VPA every time a resident calls a faculty member at home for advice on a case when the faculty member hasn't established a personal VCPR?
- Is a clinical nutritionist in violation of the VPA every time a consult is provide and a therapeutic diet is formulated by this same standard. The standard as written is well intentioned but fails to facilitate the conventional and advanced standards of care.

(3) Telemedicine is widely used in California in the form of Antech and IDEXX's consulting services. There also are a very large number of teleradiology firms operating within our state potentially in violation of the VCPR.

We are in hope the definition of the Veterinary-Client-Patient Relationship can be revised to permit the legitimate development and application of telemedicine for the innovative delivery of veterinary services to California where no services currently exist.



## California Legislation

with links to Legislation, Executive Orders & Ballot Measures

1996

The [Telemedicine Development Act of 1996 \(SB 1665\)](#) imposed several requirements governing the delivery of health care services through telemedicine, as defined including various requirements in regard to the provision of, or payment for, telemedicine services.

1997

[SB 922](#) amended the Telemedicine Development Act of 1996 to exclude from the definition of telemedicine, telephone conversations and electronic mail messages between a health care practitioner and a patient. Extended the rights granted to a patient of telemedicine to the patient's legal representative. Revised protections granted to patients of telemedicine to require application of existing laws regarding patient access to medical information and copies of medical records and surrogate decisionmaking.

1998

[AB 2780](#) established minimum standards for audio and visual telemedicine systems and would require the Department of Health Services to report to the appropriate committees of the Legislature by January 1, 2000, on the application of telemedicine to provide various types of care. Also defined "interactive" to mean an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.

2000

[AB 2877](#) indefinitely extended the Telemedicine Act of 1996 provisions for telemedicine coverage by Medi-Cal.

2002

[AB 442](#) required the State Department of Health Services to allow psychiatrists to receive fee-for-service Medi-Cal reimbursement for services provided through telemedicine until June 30, 2004, or until a method for reimbursement is developed, as provided.

2003

[AB 116](#) included that the provisions of law regulating telemedicine apply to the practice of a dentist, a podiatrist, a psychologist, a marriage and family therapist, and a clinical social worker.

2005

[AB 354](#) until January 1, 2009, authorizes under the Medi-Cal program, to the extent that federal financial participation is available, "teleophthalmology and teledermatology by store and forward," as defined.

2006

[Executive Order S-12-06](#) allocated \$240 million to achieve full information exchange between health care providers and stakeholders within ten years.

[Executive Order S-23-06](#) established a broadband task force to promote broadband access and usage.

2007

**AB 329** authorizes the Medical Board of California to establish a pilot program to expand the practice of telemedicine, and would authorize the board to implement the program by convening a working group. The bill would specify that the purpose of the pilot program would be to develop methods, using a telemedicine model, of delivering health care to those with chronic diseases and delivering other health information. Requires the Medical Board of California to make recommendations to the Legislature within one year of the commencement date of the program.

**AB 1224** defines the practice of optometry as including the treatment of primary open-angle glaucoma with the participation, as specified, of a collaborating ophthalmologist. Makes a licensed optometrist subject to “interactive” telemedicine provisions and would define collaborating ophthalmologist for purposes of his or her participation in treating primary open angle glaucoma.

**AB 234** imposes a 125-hour limitation on experience for the marriage and family therapist licensure examination earned providing personal psychotherapy services via telemedicine and would modify the definition of professional enrichment activities for these purposes.

**Executive Order S-06-07** advances the adoption of health information technology, increases transparency of quality and pricing information, and promotes quality and efficiency of health care services.

## 2008

**AB 2120** extends authorization of the Medi-Cal program, to the extent that federal financial participation is available, “teleophthalmology and teledermatology by store and forward,” as defined until January 1, 2013.

## 2009

**AB 175** includes within the definition of teleophthalmology and teledermatology store and forward services for Medi-Cal coverage consults by optometrists who are trained to diagnose and treat eye disease.

**SB 33** amend Sections 1277 and 123115 of the Health and Safety Code, relating to marriage and family therapy licensure. Increased the number of hours to no more than 375 hours of experience providing personal psychotherapy, crisis counseling, or other counseling services via telemedicine.

## 2011

**AB 415** was an update to the Telemedicine Act of 1996. It allows for the provision of a broader range of telehealth services, expansion of telehealth providers to include all licensed healthcare professionals, expansion of telehealth care settings and the ability for California hospitals to establish medical credentials for telehealth providers more easily.

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## Telehealth Facts

Barriers to telehealth  
use include  
concerns about  
costs and return on  
investment, clinician  
resistance, lack of  
broadband  
connectivity, and

interstate practice  
issues.

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## Practicing Medicine Through Telehealth Technology

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### **IN CALIFORNIA:**

**Telehealth (previously called telemedicine) is seen as a tool in medical practice, not a separate form of medicine.**

There are no legal prohibitions to using technology in the practice of medicine, as long as the practice is done by a California licensed physician. Telehealth is not a telephone conversation, email/instant messaging conversation, or fax; it typically involves the application of videoconferencing or store and forward technology to provide or support health care delivery.

The **standard of care** is the same whether the patient is seen in-person, through telehealth or other methods of electronically enabled health care. Physicians need not reside in California, as long as they have a valid, current California license.

In 1996, [Senate Bill 1665](#) (M. Thompson; Chap 864, Stats of 1996) enacted the "Telemedicine Development Act of 1996" which imposed several requirements governing the delivery of health care services through telemedicine and also made several changes to different sections of law, which are also related to telemedicine.

Below we have listed a few highlights of Senate Bill 1665:

- The act shall 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.
- Exempts out-of-state practitioners, as defined, from the Medical Practice Act when consulting either within this state or across state lines, with a licensed practitioner in California. Prohibits the out-of-state practitioner from having ultimate authority over the care or primary diagnosis of a patient in California.
- Requires the practitioner to obtain verbal and written informed consent from the patient prior to delivering health care via telemedicine, and also requires that this signed written consent statement becomes part of the patient's medical record.
- Provides that no health care service plan contract that is issued, amended, or renewed, on and after January 1, 1997, shall require face-to-face contract between a health care provider and patient for services appropriately provided through telemedicine, subject to all terms and conditions of the contract agreed upon.

In 2011, AB 415 repealed existing law related to telemedicine and replaced this law with the Telehealth Advancement Act of 2011, which revises and updates existing law to facilitate the advancement of telehealth as a service delivery mode in managed care and the Medi-Cal program. This bill repeals and replaces section 2290.5 of the Business and Professions Code to do the following:

- Defines "Asynchronous store and forward" as the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.
- Defines "Distant Site" as a site where a health care provider is located while providing services via a telecommunications system.
- Defines "Originating Site" as a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward transfer occurs.

- Defines “telehealth” as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at the distant site. States that telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.
- States that this section shall not be construed to alter the scope of practice of any health care provider.
- Provides that all laws regarding the confidentiality of health care information and a patient’s rights to his or her medical information shall apply to telehealth interactions.
- This bill also applies the Business and Professions Code Section to the laws relating to Health Care Service Plans and to the Insurance code and requires health care service plans and health insurance companies to adopt payment policies to compensate health care providers who provide covered health care services through telehealth. This bill also applies these requirements to the Medi-Cal managed care program.

**Physicians using telehealth technologies to provide care to patients located in California must be licensed in California and must provide an appropriate prior exam to diagnose and/or treat the patient.** Physicians practicing via telehealth are held to the same standard of care, and retain the same responsibilities of providing informed consent, ensuring the privacy of medical information, and any other duties associated with practicing medicine.

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# The Telehealth Advancement Act of 2011

## Opportunities for Innovation in California

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On Oct. 7, 2011, Gov. Edmund G. Brown, Jr., signed into law the Telehealth Advancement Act of 2011 (AB 415). The Act was authored by Assemblyman Dan Logue (R, Lake Wildwood) and sponsored by the California State Rural Health Association (CSRHA). AB 415 enjoyed impressive bi-partisan support, with four Democratic co-authors: Wesley Chesbro (D-North Coast), Cathleen Galgiani (D-Livingston), Richard Pan (D-Natomas), and V. Manuel Pérez (D-Coachella).

The Act, which went into effect Jan. 1, 2012, makes significant changes to California telehealth laws. It creates better parity between health care services delivered via telehealth and delivered in person, and further distinguishes telehealth as a mode of delivering services.

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A joint issue brief from the Center for Connected Health Policy and the California Telemedicine and eHealth Center.

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AB 415 removes barriers, real or perceived, that have hampered implementation of telehealth. AB 415 creates opportunities to further the use of telehealth, with the goal of providing better care, access and efficiencies.

AB 415 **does not mandate** the use or reimbursement of any telehealth services by public or private payers. Covered services, and the locations of their delivery, are still negotiated in contracts between health plans and providers, and in public insurance programs such as Medi-Cal, the state's Medicaid program. Nor does AB 415 change the scope of practice of any licensed health professional, or change interstate licensure laws.

The following is an assessment by the California Telemedicine and eHealth Center (CTEC) and the Center for Connected Health Policy (CCHP) on the impacts of AB 415.

## What AB 415 Does

### **AB 415 replaces the terminology of “telemedicine” with “telehealth” in California law.**

Under the old law's terminology, telemedicine was defined as the practice of medicine via live video connections between patients and providers in separate locations, or via “data communications.” Telephone and email were explicitly excluded. As technological advances resulted in new telehealth treatment options, this legal definition over time created unintentional obstacles to the expansion of telehealth, and became a barrier to implementation.

In addition, while the old law referenced data communications, it did not explicitly reference in its definitions the use of store & forward technologies, a prominent type of delivery means, as a part of telehealth. Store & forward connects primary care providers (PCPs) and medical specialists via sophisticated high speed, high definition communications systems without the patient being present. While store & forward was allowed in a separate section of the old law, the lack of a clear and explicit presence in the definitions section created difficulties for providers seeking reimbursement for them.

Telehealth, the new legal terminology, refers to the technology-enabled delivery of services, rather than a specific medical practice. This allows for a far broader range of telehealth than the old law, and does not limit future telehealth technologies, because of its encompassing, forward-looking definitions.

**AB 415 removes limits on the physical locations where telehealth delivered services may be provided.**

Under the old state law, there was no explicit restriction to the location where telemedicine could be delivered, other than that the facility had to be licensed. However, Medi-Cal restricted delivery and receipt of telemedicine services to four specific licensed facilities: hospitals, clinics, doctors' offices, and skilled nursing facilities. This small list of facilities was perceived as the only locations in which telemedicine could be provided.

AB 415 clears up the confusion on location by explicitly removing limits on the settings for telehealth. This will **allow** for services delivered via telehealth to be covered, regardless of where it takes place. For example, this can include services such as patient care management programs that employ home monitoring devices, in-home patient medical appointments, and provider reviews, in any location, of store & forward patient cases. However, locations for telehealth are still subject to policies and contracts enacted by Medi-Cal and private payers.

**AB 415 eliminates the ban on services provided via email or telephone being included as "telehealth."**

AB 415 removes the restriction on telephone and email as a part of the definition of telehealth, but AB 415 did not mandate that services be provided in either manner, or reimbursement made for it. Only the restriction in current law is removed.

**AB 415 expands the definition of health care provider, to include all health care professionals licensed by the State of California.**

Under the old law, only these health professionals could provide services via telehealth:

- Physicians
- Surgeons
- Podiatrists
- Clinical psychologists
- Marriage, family and child counselors
- Dentists
- Optometrists (in limited scope)

AB 415 expands this list to include all professionals licensed under the state's healing arts statute, which also include:

- Pharmacists
- Nurse practitioners
- Physician assistants
- Registered nurses
- Dental hygienists
- Physical therapists
- Occupational therapists
- Speech and language pathologists
- Audiologists
- Licensed vocational nurses
- Psychologists
- Osteopaths
- Naturopaths

The expanded definition of provider allows for a substantial expansion of licensed providers and the corresponding service types they are able to provide via telehealth. However, reimbursement for telehealth is still subject to policies and contracts enacted by Medi-Cal and private payers.

**AB 415 allows California hospitals to use new federal rules to more easily establish medical credentials of telehealth providers.**

An amendment added to AB 415 during its legislative approval process helped clear up confusion among California regulators over a new federal rule to streamline the process for establishing medical credentials of telehealth providers.

The federal Centers for Medicare and Medicaid Services (CMS) issued new regulations in July 2011 that speed the approval process of medical credentials for telehealth practitioners.

The new federal regulations allow hospitals engaged in telehealth to accept the credentialing paperwork from the telehealth provider's original facility to use in determining whether the hospital would extend privileges to that specific provider. These new regulations make for quicker approvals of practitioners, and eliminate duplicative, expensive, and often cumbersome credentialing processes.

The new CMS rules also allow sites other than hospitals, such as physician offices and ambulatory centers, to use the same privileging by proxy approvals for telehealth services at a hospital, as long as those services meet the hospital's conditions of practice.

AB 415 aligns California law with the new CMS regulations. The confusion among California regulators centered on whether existing state regulations were in conflict with the new federal rules, and hospitals still would have to go through full state credentialing processes for all telehealth practitioners. Hospitals may use the credentialing process outlined in CMS regulations, but it is not mandatory. Should a hospital wish to undertake the full credentialing vetting process of a telehealth provider, it may still do so.

**AB 415 removes two Medi-Cal regulations viewed as restrictive to services provided via telehealth.**

AB 415 eliminated a Medi-Cal rule requiring providers to document a barrier to an in-person visit before a beneficiary could receive services via telehealth, which was widely viewed as a disincentive by providers to utilize telehealth.

Additionally, AB 415 eliminated the sunset date on the Medi-Cal reimbursed store & forward specialties of teledermatology, teleophthalmology and a small set of services for teleoptometry. Reimbursement for these services would have ended in 2013.

**AB 415 changes the requirement of an additional written patient consent specifically for telehealth delivered services to a verbal consent.**

The old law required that patients sign a separate, telehealth-specific consent form prior to receiving any type of services via telehealth. This stigmatized the field, and created an unnecessary barrier to care. In the medical field, written consents are often viewed as the equivalent of flagging a procedure as risky or experimental.

AB 415's removal of a written consent establishes parity between services provided in person and services provided via telehealth.

This provision is not a blanket removal of all written consent. It simply puts telehealth more in alignment with services delivered in person, by eliminating the **additional** written informed consent that existed in law. The new law requires that a verbal consent will still need to be obtained at the originating site, prior to services provided via telehealth and the consent be documented in the patient's medical record.

## About This Issue Brief

This issue brief on the impacts of the Telehealth Advancement Act of 2011 was a joint project of the California Telemedicine and eHealth Center (CTEC), and the Center for Connected Health Policy (CCHP).

### About CCHP

Established in 2008 by the California HealthCare Foundation, the Center for Connected Health Policy (CCHP) is a non-profit planning and strategy organization working to remove policy barriers that prevent the integration of telehealth technologies into California's health care system. CCHP conducts objective policy analysis and research, develops non-partisan policy recommendations, and manages innovative telehealth demonstration projects.

[www.connectedhealthca.org](http://www.connectedhealthca.org)

### About CTEC

With more than 15 years' telehealth experience, CTEC is one of the country's leading resources for telehealth education, expertise, and implementation guidance. A federally designated Telehealth Resource Center, CTEC is the go-to source for unbiased information, serving healthcare providers, health systems, clinics and government agencies. Working to make telehealth services widely available, CTEC creates systems that make people healthier, increase access to care, improve patient outcomes, drive down healthcare costs, and sustain a reduced-carbon economy. For more information on CTEC, please visit [www.cteonline.org](http://www.cteonline.org).



## Assembly Bill No. 415

### CHAPTER 547

An act to repeal and add Section 2290.5 of the Business and Professions Code, to repeal and add Section 1374.13 of the Health and Safety Code, to repeal and add Section 10123.85 of the Insurance Code, and to amend Sections 14132.72 and 14132.725 of the Welfare and Institutions Code, relating to telehealth.

[Approved by Governor October 7, 2011. Filed with  
Secretary of State October 7, 2011.]

#### LEGISLATIVE COUNSEL'S DIGEST

AB 415, Logue. Healing arts: telehealth.

(1) Existing law provides for the licensure and regulation of various healing arts professions by various boards within the Department of Consumer Affairs. A violation of specified provisions is a crime. Existing law defines telemedicine, for the purpose of its regulation, to mean the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Existing law requires a health care practitioner, as defined, to obtain verbal and written informed consent from the patient or the patient's legal representative before telemedicine is delivered. Existing law also imposes various requirements with regard to the provision of telemedicine by health care service plans, health insurers, or under the Medi-Cal program, including a prohibition on requiring face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine, subject to certain contracts or policies. Existing federal regulations, for the purposes of participation in the Medicare and Medicaid programs, authorize the governing body of a hospital whose patients are receiving telemedicine services to grant privileges based on its medical staff recommendations that rely on information provided by the distant-site hospital. Existing state regulations require medical staff, appointed by the governing body of a hospital, to adopt procedures for the evaluation of staff applications for credentials and privileges. Existing law provides that health care service plans and health insurers shall not be required to pay for consultations provided by telephone or facsimile machines. Existing law provides that a willful violation of the provisions governing health care service plans is a crime.

This bill would delete the provisions of state law regarding telemedicine as described above, and would instead set forth provisions relating to telehealth, as defined. This bill would require a health care provider, as defined, prior to the delivery of health care via telehealth, to verbally inform the patient that telehealth may be used and obtain verbal consent from the

patient. This bill would provide that failure to comply with this provision constitutes unprofessional conduct. This bill would, subject to contract terms and conditions, also preclude health care service plans and health insurers from imposing prior to payment, certain requirements regarding the manner of service delivery. This bill would establish procedures for granting privileges to, and verifying and approving credentials for, providers of telehealth services. By changing the definition of a crime applicable to health care service plans, the bill would impose a state-mandated local program.

(2) Existing law prohibits a requirement of face-to-face contact between a health care provider and a patient under the Medi-Cal program for services appropriately provided through telemedicine, subject to reimbursement policies developed by the Medi-Cal program to compensate licensed health care providers who provide health care services, that are otherwise covered by the Medi-Cal program, through telemedicine.

This bill would, instead, prohibit a requirement of in-person contact between a health care provider and patient under the Medi-Cal program for any service otherwise covered by the Medi-Cal program when the service is appropriately provided by telehealth, as defined, and would make related changes.

(3) Existing law, until January 1, 2013, and to the extent that federal financial participation is available, authorizes, under the Medi-Cal program, teleophthalmology and teledermatology by store and forward, as defined.

This bill would delete the repeal of the above-described authorization.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

*The people of the State of California do enact as follows:*

SECTION 1. This act shall be known, and may be cited, as the Telehealth Advancement Act of 2011.

SEC. 2. The Legislature finds and declares all of the following:

(a) Lack of primary care providers, specialty providers, and transportation continue to be significant barriers to access to health services in medically underserved rural and urban areas.

(b) Parts of California have difficulty attracting and retaining health professionals, as well as supporting local health facilities to provide a continuum of health care.

(c) Many health care providers in medically underserved areas are isolated from mentors, colleagues, and the information resources necessary to support them personally and professionally.

(d) It is the intent of the Legislature to create a parity of telehealth with other health care delivery modes, to actively promote telehealth as a tool to

advance stakeholders' goals regarding health status and health system improvement, and to create opportunities and flexibility for telehealth to be used in new models of care and system improvements.

(e) Telehealth is a mode of delivering health care services and public health utilizing information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health care providers.

(f) Telehealth is part of a multifaceted approach to address the problem of inadequate provider distribution and the development of health systems in medically underserved areas by improving communication capabilities and providing convenient access to up-to-date information, consultations, and other forms of support.

(g) The use of information and telecommunication technologies to deliver health services has the potential to reduce costs, improve quality, change the conditions of practice, and improve access to health care, particularly in rural and other medically underserved areas.

(h) Telehealth will assist in maintaining or improving the physical and economic health of medically underserved communities by keeping the source of medical care in the local area, strengthening the health infrastructure, and preserving health care-related jobs.

(i) Consumers of health care will benefit from telehealth in many ways, including expanded access to providers, faster and more convenient treatment, better continuity of care, reduction of lost work time and travel costs, and the ability to remain with support networks.

(j) It is the intent of the Legislature that the fundamental health care provider-patient relationship cannot only be preserved, but can also be augmented and enhanced, through the use of telehealth as a tool to be integrated into practices.

(k) Without the assurance of payment and the resolution of legal and policy barriers, the full potential of telehealth will not be realized.

SEC. 3. Section 2290.5 of the Business and Professions Code is repealed.

SEC. 4. Section 2290.5 is added to the Business and Professions Code, to read:

2290.5. (a) For purposes of this division, the following definitions shall apply:

(1) "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.

(2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means a person who is licensed under this division.

(4) "Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) “Synchronous interaction” means a real-time interaction between a patient and a health care provider located at a distant site.

(6) “Telehealth” means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Prior to the delivery of health care via telehealth, the health care provider at the originating site shall verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. The verbal consent shall be documented in the patient’s medical record.

(c) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(d) This section shall 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.

(e) All laws regarding the confidentiality of health care information and a patient’s rights to his or her medical information shall apply to telehealth interactions.

(f) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(g) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, “telehealth” shall include “telemedicine” as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

SEC. 5. Section 1374.13 of the Health and Safety Code is repealed.

SEC. 6. Section 1374.13 is added to the Health and Safety Code, to read:

1374.13. (a) For the purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code shall apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care

services from a health care provider without in-person contact with the health care provider.

(c) No health care service plan shall require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups.

(d) No health care service plan shall limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups.

(e) The requirements of this subdivision shall also be operative for health care service plan contracts with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089) of Chapter 7, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(f) Notwithstanding any other provision, this section shall not be interpreted to authorize a health care service plan to require the use of telehealth when the health care provider has determined that it is not appropriate.

SEC. 7. Section 10123.85 of the Insurance Code is repealed.

SEC. 8. Section 10123.85 is added to the Insurance Code, to read:

10123.85. (a) For purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code shall apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the health care provider.

(c) No health insurer shall require that in-person contact occur between a health care provider and a patient before payment is made for the services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the policyholder or contractholder and the insurer, and between the insurer and its participating providers or provider groups.

(d) No health insurer shall limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided by telehealth, subject to the terms and conditions of the contract between the policyholder or contract holder and the insurer, and between the insurer and its participating providers or provider groups.

(e) Notwithstanding any other provision, this section shall not be interpreted to authorize a health insurer to require the use of telehealth when the health care provider has determined that it is not appropriate.

SEC. 9. Section 14132.72 of the Welfare and Institutions Code is amended to read:

14132.72. (a) For purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code shall apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider.

(c) In-person contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telehealth, subject to reimbursement policies adopted by the department to compensate a licensed health care provider who provides health care services through telehealth that are otherwise reimbursed pursuant to the Medi-Cal program. Nothing in this section or the Telehealth Advancement Act of 2011 shall be construed to conflict with or supersede the provisions of Section 14091.3 of this code or any other existing state laws or regulations related to reimbursement for services provided by a noncontracted provider.

(d) The department shall not require a health care provider to document a barrier to an in-person visit for Medi-Cal coverage of services provided via telehealth.

(e) For the purposes of payment for covered treatment or services provided through telehealth, the department shall not limit the type of setting where services are provided for the patient or by the health care provider.

(f) Nothing in this section shall be interpreted to authorize the department to require the use of telehealth when the health care provider has determined that it is not appropriate.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all-county letters, provider bulletins, and similar instructions.

SEC. 10. Section 14132.725 of the Welfare and Institutions Code is amended to read:

14132.725. (a) Commencing July 1, 2006, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for teleophthalmology and teledermatology by store and forward. Services appropriately provided through the store and forward process are subject to billing and reimbursement policies developed by the department.

(b) For purposes of this section, “teleophthalmology and teledermatology by store and forward” means an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology or, for teleophthalmology, by an optometrist who is licensed pursuant to Chapter 7 (commencing with

Section 3000) of Division 2 of the Business and Professions Code, where the physician or optometrist at the distant site reviews the medical information without the patient being present in real time. A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician or optometrist, and shall receive an interactive communication with the distant specialist physician or optometrist, upon request. If requested, communication with the distant specialist physician or optometrist may occur either at the time of the consultation, or within 30 days of the patient's notification of the results of the consultation. If the reviewing optometrist identifies a disease or condition requiring consultation or referral pursuant to Section 3041 of the Business and Professions Code, that consultation or referral shall be with an ophthalmologist or other appropriate physician and surgeon, as required.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all-county letters, provider bulletins, and similar instructions.

(d) On or before January 1, 2008, the department shall report to the Legislature the number and type of services provided, and the payments made related to the application of store and forward telemedicine as provided, under this section as a Medi-Cal benefit.

SEC. 11. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.