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Overview

Thanks to rapid advances in technology, the use of telehealth/telemedicine has begun to revolutionize the way healthcare providers care for their patients. In a nutshell, telemedicine is the delivery of direct patient care medical services via electronic communication. For a rural state such as New Mexico, the use of telemedicine is especially important due to its potential to alleviate our widespread provider shortages by remotely connecting rural and underserved areas with physicians and specialists. Telemedicine also serves to provide medical services to patients who are too ill or frail to be transported. While the potential benefits of telemedicine are undeniable, there is significant concern and confusion as to how the existing statutory and regulatory frameworks apply to this new area of healthcare. We hope that this issue of *New Mexico Lawyer* will not only be of interest to those attorneys who represent healthcare and telemedicine providers, but also will introduce other practitioners to core health law concepts such as HIPAA, licensing, and reimbursement.

Generally, medical specialties that utilize telehealth are: neurology, psychiatry, dermatology, family medicine, internal medicine, cardiology, critical care, rehabilitation, pediatrics, obstetrics/gynecology, speech-language pathology, and pharmacy.

Telehealth in New Mexico: Billing and Reimbursement

By Catherine Russell

According to the Health Resources and Services Administration, 32 of the 33 New Mexico counties have at least one Health Professional Shortage Area.¹ Telehealth, the use of telecommunications technologies to expand access to health care, public health, and health education, has the potential to help reach such areas. This is especially true in rural communities, where access to health care is particularly problematic. For New Mexicans living in rural and underserved areas, telehealth and telemedicine offer the opportunity to have access to resources not previously available. While telehealth may solve many issues faced by those living in (and those providing medical care in) shortage areas, it is important to be aware of billing and reimbursement rules that are particular to telehealth and telemedicine.

Billing and reimbursement are common concerns for many health care clients. While billing and reimbursement are relatively simple concepts, the rules regarding billing and reimbursement are incredibly complex. These complexities are potentially exacerbated by telehealth and telemedicine scenarios. In order to understand the intricacies of telemedicine reimbursement under the various programs, it is important to have a basic understanding of the key elements of each program and the general billing and reimbursement rules of each program.

Medicare

Medicare is a federal health insurance program for individuals age 65 or older. Medicare also covers people younger than 65 who have certain disabilities and all individuals who have end-stage renal disease.² The primary pieces of the original Medicare program are Part A (hospital insurance) and Part B (medical insurance). Most elderly individuals do not pay a monthly premium for Part A because they have already done so through previous payroll taxes. Conversely, most individuals pay a premium for Part B or for prescription drug coverage (Part D). Telehealth services, if covered, may be covered through Part B.

Medicare will pay for a limited number of Part B eligible services furnished through a telehealth system.³ To understand which services are eligible, it is important to understand the commonly used terminology. "Originating site" means the location of the patient at the time that the service is being furnished. Originating sites must be authorized and include physician offices, hospitals, rural health clinics, Federally Qualified Health Centers, and Community Mental Health Centers. The "distant site" is the location of the physician or practitioner delivering the service at the time the service is furnished. Telecommunication technologies may be utilized in "real-time" or information may be asynchronous or "store and forward." Asynchronous technologies record data and send the data to a distant site for consultation at a later time.

In general, Medicare beneficiaries are only eligible for a telehealth service if the originating site is a Health Professional Shortage Area ("HPSA") outside of a Metropolitan Statistical Area or in a rural census tract or if they are located in a county outside of a Metropolitan Statistical Area. Under the Medicare program, only real-time services that permit communication between the practitioner at the distant site and the patient at the originating site are

While billing and reimbursement are relatively simple concepts, the rules regarding billing and reimbursement are incredibly complex.

permitted.⁴ Medicare, therefore, generally does not cover asynchronous services.

Professional services that are provided using telehealth technologies are billed similarly to other Part B services. Medicare may reimburse for the professional service fee, and may pay the originating site a facility fee.

Medicaid

The New Mexico Medicaid program, also known as Centennial Care, is a state-run program for low-income individuals and families who meet certain criteria.⁵ Insurers in New Mexico, including the state's Medicaid program, have been encouraged to utilize telehealth technologies. *See* NMSA 1978, § 24-25-5(B) (2007). While coverage for telehealth services under the New Mexico Medicaid program is similar to the federal Medicare program, there are important coverage differences.

Like Medicare, the New Mexico Medicaid program uses “originating site” and “distant site” to discuss the relevant locations of the patient and provider. The most important difference between the Medicare and Medicaid programs is the coverage of asynchronous telemedicine services. While Medicare excludes from coverage most services offered using asynchronous or “store and forward” telemedicine technologies, the Medicaid program includes coverage for services delivered through store and forward. 8.310.2.12(M)(3) NMAC. Coverage and provider reimbursement for services provided using telemedicine technologies mirrors the coverage and reimbursement for similar in-person services. 8.310.2.12(M)(1) NMAC. Telemedicine providers are reimbursed for professional services and the originating site may be reimbursed for a communication system fee. 8.310.2.12(M)(4)-(5) NMAC.

Private Insurance

In general, private insurance companies enjoy more freedom in determining which services will be covered. However, in 2013, the New Mexico Legislature passed a law stating that private insurers in New Mexico must cover telemedicine services to the same extent that those services are covered in-person. NMSA 1978, § 59A-22-49.3 (2013). The law broadly defines telemedicine to include “the use of interactive simultaneous audio and video or store-and-forward technology.” S.B. 0069, 51st Leg., 1st Sess. (N.M. 2013). This broad coverage requirement indicates a state-wide commitment to the use of telemedicine and telehealth technologies.



Conclusion

In short, in order to ensure reimbursement under various insurance programs for telehealth and telemedicine services, providers must understand the rules and regulations governing each program. Providers should consider the location of the patient, whether the technology is offered in real-time, and whether reimbursement is multi-part (i.e., professional service fee and facility fee). By understanding the relevant rules and regulations, providers may successfully use telehealth technologies to offer services to New Mexicans, especially those living in rural communities. ■

Endnotes

¹ *See* U.S. Department of Health and Human Services, Health Resources and Services Administration, *Find Shortage Area: HPSA by State and County, New Mexico*, available at <http://hpsafind.hrsa.gov/HPSASearch.aspx> (last visited Sept. 15, 2014).

² Centers for Medicare and Medicaid Services, *Original Medicare (Part A and B) Eligibility and Enrollment*, available at <http://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol/> (last visited Sept. 15, 2014).

³ Centers for Medicare and Medicaid Services, *Telehealth Services: Rural Fact Sheet Series*, available at <http://www.cms.gov/Outreach-and-Education/Medicare->

[Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcfsctst.pdf](#) (last visited Sept. 15, 2014).

⁴ However, store and forward technology is permitted in Federal demonstration programs in Alaska and Hawaii; *See also* U.S. Department of Health and Human Services, HRSA, *What are the reimbursement issues of telehealth?*, available at <http://www.hrsa.gov/healthit/toolbox/RuralHealthIT/toolbox/Telehealth/whatarethereimbursement.html> (last visited Sept. 15, 2014).

⁵ Eligibility is determined based on percentage of FPL (Federal Poverty Level) and other criteria. Adults are eligible at 138% FPL, Children 6-19 are eligible at 190%, Children 0-6 are eligible at 240%. *See* Federal Poverty Guidelines, New Mexico Affordable Care Eligibility Groups, Effective April 01, 2014 thru March 31, 2015, available at http://www.hsd.state.nm.us/uploads/FileLinks/26463f122f47474487faec4922e09ce8/2014_FPL_for_HSD_Website.pdf (last visited Sept. 15, 2014).

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HIPAA

Compliance for Telemedicine Providers

By Ryan H. Harrigan

Technological advances are rapidly revolutionizing the way the healthcare industry provides care to its patients. While the potential benefits of these advances is undeniable, the changes have created significant uncertainty and confusion on behalf of medical providers as to how to remain compliant with federal/state regulations, specifically those related to protecting the privacy of patients' health information.

Fortunately, the treatment and diagnostic potential of these advances in New Mexico has not gone unnoticed. After the 2014 legislative session, Gov. Susana Martinez signed into law a state budget that included \$600,000 for the Department of Health to expand telemedicine services in the state and a \$500,000 increase for Project ECHO (Extension for Community Healthcare Outcomes), an internationally recognized telehealth model established at the University of New Mexico more than a decade ago.

As telemedicine necessarily requires the spread of health information and treatment over the Internet, there is an understandable increase in concern over ensuring that patients' sensitive health information is protected. The Health Insurance Portability and Accountability Act (HIPAA), which was signed into law in 1996 (Public Law 104-191), is the federal regulatory scheme that serves to protect patients' health information.¹ HIPAA requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards for electronic transactions, including data elements, standard code sets, unique health identifiers, security safeguards and privacy standards. Along with HIPAA, the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, addresses



the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules. Failure to comply with and/or violate the provisions of HIPAA/HITECH can result in severe civil and/or criminal penalties.

Who Does HIPAA Apply To?

The critical question for telemedicine providers to determine is whether HIPAA applies to them, and, if so, what steps must they take to comply with HIPAA. HIPAA only applies to *covered entities* that engage in the use or disclosure of individuals' *protected health information*. Thus, in order to determine if a telemedicine provider is subject to HIPAA, the first level of analysis is whether they are deemed a "covered entity" under HIPAA. Covered entities under HIPAA are: (1) health plans; (2) health care clearinghouses; or (3) any health care provider who transmits health information in electronic form

in connection with certain transactions. 45 CFR 160.103. If the entity is determined to be a covered entity, the analysis turns to whether any information being received, used or disclosed meets the definition of "protected health information." Protected Health Information or PHI is defined as information that "[i]s created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse;" and "[r]elates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual." Id.

If HIPAA applies, a covered entity is only permitted to use and disclose protected health information, without an individual's authorization, in the following instances: (1) to the individual; (2) for treatment, payment, and health care operations; (3) incident to an otherwise permitted use and disclosure; (4) for certain public interest and benefit activities; and (5) as a limited data set for the purposes of research, public health or health care operations.² However, even if a covered entity is allowed to use/disclose a patient's protected health information, the covered entity must still make reasonable efforts to use, disclose, and request *only the minimum amount* of protected health information needed to accomplish the intended purpose of the use, disclosure, or request.³ In order to ensure compliance with HIPAA, a covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary.

Who Can Protected Health Information Be Shared With?

A reality of telemedicine is that healthcare providers will often require the services of

third-party entities to effectively perform services remotely. These third parties might be teleconferencing platforms, internet service providers or cloud-based data storage providers, to simply name a few. For telemedicine to function effectively and efficiently it will often be necessary for a health care provider to send protected health information either to or through these third parties. While HIPAA allows covered providers to disclose protected health information to these third-party “business associates,” certain requirements must be met to ensure that safeguards are in place to protect the health information being shared. When a covered entity uses one of these third-party platforms, certain protections must be included in a written *business associate agreement* between the covered entity and the business associate. 45 CFR 164.502(e).

An exception to the requirement of maintaining a business associate agreement with a third party exists if that third party is acting purely as a conduit of health information and does not store the information. This “conduit exception” is

Examples of Identifiable Information Under HIPAA

- Name
- ZIP code
- Address
- Name of employer
- Birth date
- Telephone number
- Fax number

What is a Business Associate?

A person or organization, other than a member of a covered entity's workforce, that:

- performs certain functions or services that involve the use or disclosure of PHI
- creates, receives, maintains, or transmits PHI on behalf of the business associate or the covered entity.

Business associate functions or activities can include:

- claims processing
- data analysis
- utilization review
- billing

limited to transmission services (whether digital or hard copy), including any temporary storage of transmitted data incident to such transmission. See 78 Federal Register 5571-5572. The transient versus persistent nature of opportunity to view data is relevant. If the third party stores or keeps PHI on behalf of a covered entity it will be deemed a business associate, even if the entity does not view the PHI. Covered entities that practice telemedicine should err on the side of caution when applying the conduit exception, as the government has been clear that this exception is not intended to be broad: “the conduit exception ... is intended to exclude only those entities providing mere courier services, such as the U.S. Postal Service or United Parcel Service and their electronic equivalents, such as Internet service providers (ISPs) providing mere data transmission services.” See 78 Federal Register 5571.

Why Is HIPAA Compliance Important?

A telemedicine provider's compliance with HIPAA is important in order to avoid: (1) breaches of patients' health information; and (2) the significant penalties imposed for failing to comply with HIPAA. In the event of a breach of patients' privacy, HIPAA requires that covered entities and business associates provide notification to affected individuals.⁴ If a breach has occurred, a covered entity is required to notify affected individuals without unreasonable delay but not later than 60 calendar days after discovery. If the breach affects fewer than 500 individuals, the covered entity may maintain a log of the breaches and submit this log annually to HHS. However, if the breach affects 500 or more individuals, then the notice must also be provided to HHS and major media outlets serving New Mexico. Understandably, notifying patients (and potentially the media) that patients' sensitive medical records have been compromised can be an embarrassing and damaging situation for many healthcare providers.

It is important for telemedicine providers to note that the breach notification requirement only applies to protected health information that is “unsecured.” If the protected health information is rendered “unusable, unreadable, or indecipherable” to unauthorized individuals, it is deemed secure. In sum, in order for protected health information to

be secure it needs to be either encrypted or destroyed. In choosing platforms/methods to perform telemedicine, providers must take care to select those service providers who can ensure that any electronic protected health information is encrypted in accordance with HIPAA. Similarly, if electronic health information is to be destroyed, the telemedicine provider must ensure that the electronic media is cleared, purged, or destroyed so that the protected health information cannot be retrieved, consistent with HIPAA guidelines. Failure to comply with HIPAA can also result in significant penalties for healthcare providers. Under HIPAA, penalties can include:

- \$100 to \$50,000 per violation. (Up to \$1,500,000, per year)
- \$50,000 fine and up to one year in prison for improperly obtaining or disclosing health information.
- \$100,000 fine and up to five years in prison for obtaining or disclosing health information under false pretenses.
- \$250,000 fine and up to 10 years in prison for obtaining health information with the intent to sell, transfer or use for commercial advantage, personal gain or malicious harm.⁵

The breach notification requirements and penalties associated with HIPAA can have the unfortunate consequence of dissuading risk-averse healthcare providers from venturing into the new world of telemedicine. However, by investing the time to learn the nuances of HIPAA and implementing a culture of compliance, healthcare providers can take advantage of the many benefits that telemedicine has to offer for both patients and providers alike. ■

Endnotes

¹ 45 CFR Parts 160 and 164

² See, e.g. 45 CFR 164.506; 45 CFR 164.512(b)

³ 45 CFR 164.502(b), 164.514(d)

⁴ The HIPAA Breach Notification Rule can be found at 45 CFR §§ 164.400-414.

⁵ 42 U.S.C. §1320d-5; 42 U.S.C. §1320d-6

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Regulation of Mobile Medical Apps

By Erin Joyce Jackson and Ryan Harrigan

Another area of the healthcare industry that is rapidly developing and evolving is the use of mobile medical applications (app). The U.S. Food and Drug Administration estimates that 500 million smartphone users will use a mobile medical application by 2015, and 1.7 billion worldwide users by 2018. Apps allow users to integrate their smartphones with increasingly complex medical technology, whereby their smartphones can actually become medical devices. A physician may use a mobile medical app to conduct a patient's ECG, a pharmacist may use one to verify potential drug interactions, and diabetic patients may use one to monitor their insulin levels. The FDA's new regulation of this area of medical technology is expected to create even more complex and reliable mobile medical apps.



The FDA is responsible for regulating medical devices, and the emerging role of these mobile medical apps threaten to create a regulatory challenge. In 2011, the FDA released its draft regulations for these apps, and in September 2013, it released its final guidance. While the final guidance only regulates the behavior of mobile medical app manufacturers, the ramifications could be felt by all users.

Three New Categories of Apps

In the final guidance, the FDA created three categories of mobile medical apps:

- (1) those that it will regulate as medical devices;
- (2) those over which it will exercise enforcement discretion; and
- (3) those that will be subject to no regulation.

The level of regulation that the FDA will exercise over an app directly correlates to the app's potential for risk to patients. The comments received about the proposed rules overwhelmingly supported this tiered, risk-based approach.

Many mobile medical apps are aimed at the patient-consumer, and they perform such diverse functions as allowing patients to record findings in breast self-exams, track moles and skin cancer risk factors, or monitor their multiple sclerosis injection schedule.

The FDA will focus its regulatory and enforcement power on a small subset of mobile medical apps that it considers to be medical devices and which, if they fail to function properly, present the greatest risk to patients. These apps include: (a) those that are accessories to regulated medical devices, such as one that allows physicians to review x-ray images on their smartphones, and (b) those that transform a smartphone into a regulated medical device, such as those that turn the provider's smartphone into an ECG or ultrasound machine.¹ These apps may also use attached sensors to provide feedback

for various situations, such as to determine the quality of CPR being delivered, to analyze eye movements and diagnose balance disorders, or to measure the degree of tremors produced by diseases. These apps will be regulated like any other medical devices.

The FDA will exercise enforcement discretion over the second category of apps, meaning that it will largely refrain from enforcing the requirements of the Federal Drug & Cosmetic Act (FDCA) over these apps. Even if these apps fall under the technical definition of a medical device, the FDA has determined that they pose a minimal risk to patient-consumers.² Examples of these apps include those that provide motivational guidance to patients who are trying to quit smoking, those that include GPS locators to alert asthmatics of environmental conditions, or those that use video games to motivate patients to follow their at-home physical therapy regimens.

The third category of apps does not meet the definition of “device” and will not be regulated by the FDA. Examples of these unregulated apps include those that allow providers to access electronic copies of medical textbooks, the DSM, or the Physician’s Desk Reference; those that are intended for provider education, rather than patient treatment, such as surgical training videos or interactive anatomy diagrams; and those that allow patients to self-educate about diseases, clinical trials, or prescription drugs.

The Impact on Providers

These regulations regulate the activities of mobile medical app manufacturers, not the apps’ consumers. However, it is important that providers limit their practice’s use of mobile medical apps to those apps that have been cleared by the FDA. If a provider is uncertain about the status of an app, there are multiple search engines available on the FDA’s website. A nonexclusive list of approved apps is also available on the FDA’s website.

Entities that rate and approve medical apps are available, and providers can consult these sources prior to purchasing an app for use in their practice that rates and approves medical apps.³ Although it does not guarantee that its rated apps are in compliance with FDA requirements, the new program Happtique offers a Health App Certification Program (HACP). HACP is the first-ever approval and certification process for mobile health apps, wherein the apps are put through technical, privacy, and content tests.⁴ Whether providers are using an app themselves or recommending it to their patients, choosing an app from Happtique’s registry, or a similar source, allows the provider to feel confident that the app has been independently tested and certified. The registry remains small and in its early developmental stages, but it allows the featured apps to stand apart from uncertified competitors. It is important to note that Happtique’s process is distinct from the FDA’s regulatory process, and Happtique’s certification and ratings of an app do not correlate to the FDA’s approval of that app.

The Impact on Patient-Users

Many mobile medical apps are aimed at the patient-consumer, and they perform such diverse functions as allowing patients to record findings in breast self-exams, track moles and skin cancer risk factors, or monitor their multiple sclerosis injection

Whether providers are using an app themselves or recommending it to their patients, choosing an app from Happtique’s registry, or a similar source, allows the provider to feel confident that the app has been independently tested and certified.

schedule. The more functional apps, however, are not available free-of-charge, and third-party payers want additional proof of outcomes before they cover the cost this technology. Because third-party payers want evidence of improved outcomes and reduced hospitalizations before they reimburse for patient mobile medical apps, the process is likely to move slowly. Thus, the most rapid developments in patient-focused apps will likely occur where there is the potential for profit, such as those that could be offered by corporations as a component of their employee health plans. While the rapidly evolving area of medical apps brings great promise to providers and patients alike, all

parties need to be cognizant of the rules and regulations affecting this new area of healthcare delivery. ■

Endnotes

¹ U.S. DEP’T OF HEALTH & HUMAN SVCS., FOOD & DRUG ADMIN., *FDA issues final guidance on mobile medical apps*, FDA NEWS RELEASE, (Sept. 23, 2013).

² U.S. DEP’T OF HEALTH & HUMAN SVCS., FOOD & DRUG ADMIN., *MOBILE MEDICAL APPLICATIONS: GUIDANCE FOR INDUSTRY AND FOOD AND DRUG ADMINISTRATION STAFF 23* (2013).

³ Rob Stott, *ASSOCIATIONS NOW, Health and Medical Apps Get Certified*, MONEY & BUSINESS (Dec. 9, 2013), <http://associationsnow.com/2013/12/health-and-medical-apps-get-certified/>.

⁴ Id.

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Telemedicine Licensing: Within and Beyond New Mexico's Borders

By Rosalyn D. Nguyen and Diana Heider

Internet and mobile technology is becoming increasingly common in the United States. According to a Gallup poll of American adults conducted in January 2014, 62 percent have a smartphone, 73 percent have wireless Internet access at home, 64 percent own a laptop computer, and 38 percent own a tablet computer.¹ With modern life becoming increasingly driven by and reliant upon technology, it makes sense that technology could be applied to healthcare to produce solutions that are cost-effective, efficient, and convenient—telemedicine.

This article examines telemedicine licensing as it applies to physicians in New Mexico, the complexities of physician telemedicine licensing in other states, and what the Federation of State Medical Boards are currently proposing to resolve interstate medical licensing issues.

New Mexico Telemedicine Licensing

To protect the public from incompetent or impaired practitioners, laws governing individual health care providers by requiring them to hold medical practice licenses are enacted through state legislative action, where the authority to regulate is delegated to the respective state licensing board. In New Mexico, this authority lies with the New Mexico Medical Board (NMMB) which grants New Mexico licenses to qualified physicians and certain other qualified healthcare providers.

New Mexico is one of 10 states that requires an out-of-state physician to obtain a special telemedicine-specific license. Accordingly, the NMMB grants telemedicine licenses under the Medical Practice Act, which defines the practice of medicine across state lines. NMSA 1978, Sections 61-6-1 through 61-6-35 (1978). New Mexico requires that a telemedicine consulting physician obtain a telemedicine



license that would allow that physician located outside New Mexico to practice medicine on patients located in New Mexico. NMAC 16.10.2.8. The applicant is required to be of good moral character and hold a full and unrestricted license to practice medicine in another state or U.S. territory. New Mexico does not allow licensure reciprocity from other states.

Differences Between Telemedicine & In-Person Standards?

Overall, New Mexico does not have any unique laws regulating the practice of telemedicine. For example, telemedicine remote providers do not have to perform an initial in-person exam nor must an in-person physician-patient relationship be established prior to a telemedicine consultation for a patient at an originating site in New Mexico. The physician-patient relationship can be established via telemedicine. Also, standards of care for telemedicine are the same as those for in-person care. Some states' laws (though not New Mexico's) specifically require that informed consent be obtained from the patient prior to the telemedicine encounter. However, the American Telemedicine Association recommends that as a best practice and to avoid liability, a patient should sign an informed consent document to indicate that the patient understands and agrees to the telemedicine encounter.

New Mexico-Licensed Physicians Practicing Telemedicine Beyond New Mexico Borders

Remote providers in New Mexico wanting to provide telemedicine to patients at out-of-state originating sites must obtain the necessary telemedicine license (if any) of that particular state. It is advisable to check the specific regulations in each state in which the physician intends to electronically practice; otherwise, practicing medicine in a state without meeting that state's telemedicine licensing requirements can incur civil and/or criminal penalties. The best practice is to research and be aware of other states' licensing requirements and the parameters for special telemedicine licensing exceptions before the need arises.

The study, "State Telemedicine Gaps Analysis: Physician Practice Standards & Licensure," released in September 2014 by the American Telemedicine Association, compared and graded all 50 states according to their current telemedicine laws. New Mexico was one of 23 states (and D.C.) that averaged a highest composite grade suggesting a supportive policy landscape that accommodates telemedicine adoption and usage based on a comparison of each state's laws and differing medical board standards regarding telemedicine.²

Interstate Medical License Compact

When the practice of telemedicine remains within New Mexico's borders, or when New Mexican patients are located at the originating site, the process of obtaining the required New Mexico telemedicine-specific license is straightforward. However, telemedicine licensing across state borders is a key issue. In the absence of a concerted effort to develop uniform or parallel medical licensing laws, each state's medical licensing laws evolved independently of each other, resulting in a patchwork of laws that are

often incongruent with one another and that present a huge challenge to establishing seamless telemedicine reciprocity.

The Federation of State Medical Boards (FSMB), a national non-profit organization that represents 70 state medical and osteopathic medicine boards and serves as the prominent U.S. authority for medical issues related to licensure and discipline nationally and internationally, recognized a need to streamline an approach for physicians to apply for medical licensure in multiple states. As a potential solution, the FSMB proposed model legislation for a new state compact initiative, the Interstate Medical License Compact (Compact), to simplify the medical licensing application process.³ Although the Compact contemplates continued reliance on state-based licensing and authority, a main objective is to improve the speed and efficiency of obtaining a license, which would in turn expand telemedicine across state lines, according to Humayun J. Chaudhry, DO, president and CEO of FSMB.

The general principle of increasing and improving access to health care remains a universal goal.

Participation in the Compact is voluntary for both the state and the physician. To be eligible for an expedited license in states that adopt the Compact, a physician must, among other things, (1) possess a full and unrestricted medical license to engage in the practice of medicine issued by a member board; (2) have successfully completed an approved graduate medical education program; (3) possess specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists; (4) have never been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction; (5) have never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to

a license; (6) have never had a controlled substance license or permit suspended or revoked by a state or the U.S. Drug Enforcement Administration; and (7) not be under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.⁴

To clarify, the Compact would not change a state's existing Medical Practice Act (or an analogous act) or create a new "national license," nor is the Compact intended to replace the original process for obtaining licensure in any individual state. Rather, the Compact would supplement the existing licensing framework by authorizing the development of an Interstate Medical License Compact Commission (Commission), which would serve as a central administrative clearinghouse for physicians applying for licensure in multiple states and thus efficiently expedite multi-state applications. Additionally, the Commission would serve as a joint agency of member states and possess the authority to promulgate rules, issue advisory opinions, enforce compliance, and collect fees. Member states' medical licensing boards would report any public action, violation of the state's Medical Practice Act (or the respective analogous act), or complaints against a licensed physician to the Commission, subjecting that physician to discipline by other member states' boards by which the physician may be licensed. Under the Compact, if a physician's license were revoked, surrendered, or relinquished, then that physician's license would automatically be placed in the same corresponding status in the other states where the physician held a medical license. Under the Compact, member states' boards are required to share complaint and investigative information with other member states' boards. Despite the Compact's new authority and requirements, a physician would still be bound to comply with the statutes, rules, and regulations of each state in which he or she holds a license.

Although there are still some open questions regarding the Compact, such as what the physician application fees will be, the FSMB finalized the model law this July and seeks to introduce this legislation to each of the 50 states at the start of each state's 2015 legislative session. According to Lynn Hart, executive director of the New Mexico Medical Board, the Board is currently reviewing the Compact to determine whether it would benefit the

state. In the meantime, applications for telemedicine licenses are being processed by the Board within an average of five to seven working days.⁵

The general principle of increasing and improving access to health care remains a universal goal. The potential advantages of technology are increasing quickly, and we have much to gain if our society's leadership and health care policy makers choose to be proactive and open to new policies, rules and regulation changes to capture efficiencies in the practice of medicine. Above all, our leadership and policy makers must be conscientious in preserving the ability to reasonably regulate the practice of medicine, while continuing to uphold the highest standards of patient care. ■

Endnotes

¹ Dugan, A. "Americans' Tech Tastes Change With Times", January 6, 2014. <http://www.gallup.com/poll/166745/americans-tech-tastes-change-times.aspx>

² Capistrant, G. & Thomas, L. "State Telemedicine Gaps Analysis: Physician Practice Standards & Licensure" by the American Telemedicine Association, September 2014. <http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis--physician-practice-standards-licensure.pdf?sfvrsn=6>

³ Federation of State Medical Boards, Interstate Medical License Compact Information Center, [http://www.fsmb.org/Media/Default/PDF/Advocacy/Interstate%20Medical%20Licensure%20Compact%20\(FINAL\)%20September%202014.pdf](http://www.fsmb.org/Media/Default/PDF/Advocacy/Interstate%20Medical%20Licensure%20Compact%20(FINAL)%20September%202014.pdf)

⁴ *Id.*

⁵ Telephone Interviews with Lynn Hart, Executive Directors, New Mexico Medical Board (September 15, 2014).

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