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A Clinical, Regulatory, and Operational Reference for Delivering High-Quality Virtual Care in 2025-2026

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SECTION 1: THE TELEHEALTH LANDSCAPE

Growth, Adoption, and Market Data ---

Telehealth has undergone a structural transformation in American healthcare delivery. What began as a pandemic stopgap has become a permanent fixture of clinical practice, reshaping how providers document encounters, bill for services, manage compliance, and maintain quality of care.

Pre-Pandemic Baseline ---

Before COVID-19, telehealth utilization was minimal. FAIR Health data showed that telehealth claims represented just 0.1% of all medical claims in 2019. The American Medical Association (AMA) Physician Practice Benchmark Survey found that only 25.1% of physicians reported using telehealth in their practices in 2018.

(Source: AMA Physician Practice Benchmark Survey, 2024; FAIR Health, 2021)

Pandemic Surge and Stabilization ---

The COVID-19 pandemic triggered an unprecedented adoption spike. By 2020, 79% of physicians reported using telehealth. The Centers for Disease Control and Prevention (CDC) documented this transformation in National Health Statistics Report No. 210 (September 2024), confirming broad demographic uptake across age groups, genders, and education levels.

Post-pandemic, utilization has stabilized at levels far above the pre-COVID baseline. As of early 2024, 54% of Americans have engaged in telehealth services, with 38% using it specifically for medical or mental health needs. Among physicians, 71.4% reported using telehealth weekly in their practices in 2024, nearly triple the 2018 rate.

(Source: CDC National Health Statistics Report No. 210, September 2024; AMA Physician Practice Benchmark Survey, 2024)

Demographic Patterns ---

Telehealth adoption is not uniform across populations:

-- Adults aged 65 and over: 43.3% have utilized telehealth services -- Adults aged 18-29: 29.4% utilization rate -- Women: 42.0% engagement rate -- Men: 31.7% engagement rate -- College graduates: 43.2% reported using telehealth -- Adults without a high school diploma: 28.7% participation

These disparities have implications for documentation, as providers must consider health literacy and technology access when designing telehealth workflows.

(Source: CDC National Health Statistics Report No. 210, September 2024)

Specialty Variation ---

The AMA 2024 data reveals significant variation by specialty:

-- Psychiatry leads adoption: 85.9% of psychiatrists reported providing a video visit in the prior week, with 56.9% using telehealth for more than 20% of weekly visits
-- Psychiatrists had the highest share of telehealth-eligible spending billed as telehealth at 31.2%
-- Primary care physicians in hospital-owned practices: 78.9% using telehealth, compared to 70.1% in private practice
-- Overall, 73.5% of physicians in hospital-owned practices used videoconferencing, compared to 58.3% in private practice

(Source: AMA, "New data details how telehealth use varies by physician specialty," 2024)

Market Projections ---

The global telehealth market was valued at approximately \$186 billion in 2025 and is projected to grow to \$219 billion in 2026, reaching over \$1.27 trillion by 2034 (CAGR of 24.6%). The U.S. telehealth market specifically is forecast to grow from \$65.35 billion in 2026 to \$358.96 billion by 2034 (CAGR of 23.84%).

Industry projections estimate that by the end of 2026, 25-30% of all medical visits in the United States will be conducted via telemedicine.

(Sources: Fortune Business Insights Telehealth Market Report, 2025; Towards Healthcare U.S. Telehealth Market Report, 2025)

Post-pandemic, 80% of physicians indicated plans to continue using telehealth, and a 2022 McKinsey report found that 40% of consumers planned to continue using telehealth -- a significant increase from just 11% pre-pandemic.

(Source: McKinsey & Company, Telehealth Report, 2022)

SECTION 2: REGULATORY FRAMEWORK

Federal and State Telehealth Policy ---

The telehealth regulatory landscape involves a complex interplay of federal Medicare policy, state licensure laws, DEA prescribing rules, and payer- specific requirements. Providers must navigate all of these simultaneously.

CMS Medicare Telehealth Policy (2025-2026) ---

The Centers for Medicare and Medicaid Services has implemented several key policies governing telehealth delivery:

Geographic and Originating Site Restrictions: Through December 31, 2026, CMS has temporarily waived geographic restrictions that previously limited Medicare telehealth to rural areas. Patients may receive telehealth services from their homes regardless of geographic location.

Eligible Services: CMS maintains a list of Medicare-covered telehealth services, updated annually. The Physician Fee Schedule Final Rule for each calendar year specifies which CPT codes are eligible for telehealth delivery. Mental health and behavioral health services have permanent telehealth eligibility.

Audio-Only Restrictions: Effective October 1, 2025, Medicare audio-only telehealth is limited to mental/behavioral health and substance use disorder services provided to patients in their home (POS 10). All other specialties require audio-video capability.

Rural Health Clinics and Federally Qualified Health Centers: Through December 31, 2026, RHCs and FQHCs may continue to bill for non-behavioral health services furnished through telecommunications technology by reporting HCPCS code G2025.

Facility Fees: Facilities serving as originating sites may bill HCPCS code Q3014 for telehealth encounters. The Medicare facility fee is \$31.85 for 2026.

(Sources: CMS Telehealth FAQ Updated 02/26/2026; CMS Telehealth and Remote Monitoring MLN901705, December 2025; CMS Telehealth FAQ Calendar Year 2025)

Proposed Changes for 2026 and Beyond ---

Providers should monitor CMS proposed rulemaking carefully. Many current telehealth flexibilities

exist under temporary extensions tied to Congressional action. If Congress does not act to make certain provisions permanent, geographic restrictions and originating site requirements could return.

(Source: Moss Adams, "Be Prepared for Important 2026 Proposed Changes to Medicare Telehealth Policy," August 2025)

SECTION 3: INTERSTATE LICENSURE

IMLC, PSYPACT, and Cross-State Practice ---

Telehealth inherently raises licensure questions because the provider and patient may be in different states. Several interstate compacts address this challenge.

Interstate Medical Licensure Compact (IMLC) ---

The IMLC provides an expedited pathway for physicians to obtain multiple state licenses. Critical points for providers:

- As of November 2025, there are 44 member jurisdictions, including
 - 42 states, the District of Columbia, and the Territory of Guam
- The IMLC is NOT a single multistate license; each participating state still issues, renews, and regulates its own license
- The compact provides expedited processing, not license portability -- Physicians must meet eligibility requirements, including holding a
 - full and unrestricted license in a member state

A notable development: Michigan's IMLC legislation included a sunset provision effective March 28, 2025. Because the legislature failed to extend it, over 5,000 physicians in Michigan were at risk of losing their compact-facilitated licenses as of March 28, 2026.

(Sources: Interstate Medical Licensure Compact Commission, imlcc.com; Consilium Staffing, "Interstate Medical Licensure Compact Updates 2025")

Psychology Interjurisdictional Compact (PSYPACT) ---

PSYPACT specifically authorizes eligible psychologists to practice telepsychology across member states:

- 43 participating states and territories as of late 2025 -- Montana became an active member in October 2025 -- The PSYPACT Commission updated its rulebook on November 18, 2025,
 - to clarify administrative and compliance provisions
- Annual PSYPACT authorization renewal fees are scheduled to increase
 - starting January 1, 2026

Unlike the IMLC, PSYPACT creates true practice authority across state lines for telepsychology, without requiring separate state licenses.

(Sources: PSYPACT Commission; HHS Telehealth.gov, "Licensure compacts"; Telehealth.org, "Telehealth Licensure 2025-2026")

Other Licensure Compacts ---

Additional compacts relevant to telehealth include:

- Nurse Licensure Compact (NLC): Allows registered nurses and licensed practical/vocational nurses to practice across state lines
- Physical Therapy Compact: Enables physical therapists and physical therapist assistants to practice in member states
- Counseling Compact: Addresses licensed professional counselors

Providers should verify their specific compact eligibility and ensure compliance with both the compact requirements and individual state telehealth laws where their patients are located.

(Source: Center for Connected Health Policy, cchpca.org)

SECTION 4: DEA TELEHEALTH PRESCRIBING

Controlled Substances and the Ryan Haight Act ---

The prescribing of controlled substances via telehealth is governed by federal law, specifically the Ryan Haight Online Pharmacy Consumer Protection Act of 2008, with critical temporary modifications.

The Ryan Haight Act ---

The Ryan Haight Online Pharmacy Consumer Protection Act largely prohibits prescribing controlled substances without an initial in-person examination. The Act's exceptions apply primarily when a patient is in a hospital, clinic, or in the presence of another practitioner -- not the routine telehealth model where patient and provider participate from home settings.

(Source: Federal Register, Ryan Haight Online Pharmacy Consumer Protection Act of 2008)

COVID-Era Flexibilities and Extensions ---

During the public health emergency, the DEA waived the in-person examination requirement. This flexibility has been extended multiple times:

Fourth Temporary Extension (2026): The DEA and HHS issued a fourth temporary extension of COVID-19 telemedicine flexibilities, effective January 1, 2026 through December 31, 2026. This rule allows DEA-registered practitioners to prescribe Schedule II-V controlled substances using telemedicine without having conducted an in-person medical evaluation, provided required conditions are met.

(Source: Federal Register, "Fourth Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications," Document 2025-24123, December 31, 2025)

Buprenorphine Special Rule: Two final rules took effect December 31, 2025: the Expansion of Buprenorphine Treatment via Telemedicine Encounter and the Continuity of Care via Telemedicine for Veterans Affairs Patients. These operate alongside the fourth temporary rule.

(Source: DLA Piper, "DEA and HHS propose telemedicine special registration and finalize buprenorphine telemedicine prescribing rules," January 2025)

Proposed Special Registration Framework ---

In January 2025, the DEA released a proposed rule establishing three special registration categories to create permanent pathways for telehealth prescribing of controlled substances after temporary flexibilities expire. However, as of early 2026, the Trump administration has not moved forward with finalizing this proposed approach.

(Source: Frier Levitt, "DEA and HHS Issue Fourth Extension of COVID-19 Telemedicine Flexibilities," 2025)

Documentation Requirements for Controlled Substance Prescribing ---

When prescribing controlled substances via telehealth, providers should document:

- The specific telehealth modality used (audio-video or audio-only) -- Clinical justification for the controlled substance -- Risk assessment, including review of prescription drug monitoring program (PDMP) data
- Treatment agreements or informed consent specific to controlled substance prescribing
- Follow-up plan, including when an in-person visit will be required -- State-specific requirements for the patient's location

Providers should be aware that these temporary flexibilities may expire at the end of 2026 if permanent rules are not finalized. Practice workflows should include contingency plans for reverting to in-person prescribing requirements.

SECTION 5: DOCUMENTATION REQUIREMENTS

What Payers Demand Beyond Standard Visit Notes ---

Telehealth documentation requirements encompass everything required for standard in-person visit documentation plus several telehealth-specific elements. Failure to include these elements creates audit risk and may result in claim denials or recoupment.

Standard Clinical Documentation (Same as In-Person) ---

The clinical content of a telehealth note must meet the same standards as an in-person visit:

- Chief complaint and history of present illness -- Review of systems (as applicable to complexity level) -- Medical decision-making elements or total time documentation -- Assessment and plan -- All elements required by the CPT or E/M code being billed

(Source: CMS Telehealth and Remote Monitoring MLN901705, December 2025)

Telehealth-Specific Documentation Elements ---

Beyond standard clinical documentation, telehealth visits require:

1. **Modality of Service Delivery:** Document whether the visit was conducted via real-time audio-video or audio-only. For audio-only visits, document that the provider had audio-video capability available but the patient either lacked video capability or declined video use.
2. **Patient Location:** Document the patient's physical location during the visit in sufficient detail to meet audit requirements. For Medicare, this determines the Place of Service code (POS 02 or POS 10) and affects reimbursement rates. Include the state where the patient is located, as this determines which state's laws apply.
3. **Provider Location:** Document where the provider (distant site) is located during the encounter.
4. **Technology Platform:** Identify the telehealth platform used and confirm it is HIPAA-compliant.
5. **Patient Consent:** Document that the patient consented to receiving care via telehealth. Requirements vary by state -- some require written consent, others accept verbal consent with documentation in the record.
6. **Time Documentation:** Document start and stop times of the encounter. For time-based billing, document total time on the encounter date, including all activities related to the patient.
7. **Technical Quality Statement:** Note the quality of the audio and video connection. If technical difficulties occurred, document them and describe how they were addressed (e.g., switched to audio-only, rescheduled).
8. **Emergency Contact Information:** For patients outside your immediate jurisdiction, document the emergency number and local resources specific to the patient's location. Note that 911 responses are dispatched based on caller location.
9. **Participants:** Document all individuals present during the telehealth encounter on both ends (e.g., caregivers, interpreters, students).

(Sources: CMS Telehealth FAQ Calendar Year 2025; Headway, "Your guide to CMS telehealth documentation requirements"; Mid-Atlantic Telehealth Resource Center, matrc.org)

Sample Telehealth Documentation Header ---

A compliant telehealth note should begin with elements similar to:

Visit Type: Telehealth - Synchronous Audio-Video

Platform: [HIPAA-compliant platform name]

Patient Location: Patient's home, [City, State]

Provider Location: [Office/Home], [City, State]

Consent: Patient provided verbal consent for telehealth visit, documented in record. Patient was informed of risks, benefits, and alternatives to telehealth, including option for in-person care.

Connection Quality: Clear audio and video throughout encounter. [OR: Video connection intermittent; switched to audio-only at [time]; clinical assessment adapted accordingly.]

Emergency Contact: Patient confirmed local emergency number and provided address for

emergency dispatch if needed.

SECTION 6: BILLING AND CODING

Place of Service Codes, Modifiers, Audio-Only, RPM, and RTM ---

Telehealth billing involves specific coding conventions that differ from in-person encounters. Errors in Place of Service codes, modifier usage, or code selection are among the most common causes of telehealth claim denials.

Place of Service Codes ---

Two Place of Service codes apply to telehealth:

POS 02 -- Telehealth Provided Other Than in Patient's Home

- Used when the patient is at a healthcare facility, clinic, or other non-home location during the telehealth encounter
- Paid at the facility payment rate (lower)

POS 10 -- Telehealth Provided in Patient's Home

- Used when the patient is located in their home -- Paid at the non-facility payment rate (higher)

The distinction between POS 02 and POS 10 directly affects reimbursement. POS 10 (patient at home) pays the non-facility rate, which is typically higher than the facility rate paid under POS 02. This payment differential was formalized beginning in CY 2024.

(Sources: CMS, "Billing and coding Medicare Fee-for-Service claims," Telehealth.HHS.gov; AAPC, "CMS Makes Telehealth POS 10 Official," 2024)

Telehealth Modifiers ---

Modifier 95: Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system. This is the primary modifier for standard audio-video telehealth visits. Used by commercial payers; Medicare uses POS codes rather than Modifier 95.

Modifier 93: Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system. Required for Medicare audio-only visits. Documentation must reflect that audio-video was available but the patient could not or chose not to use video.

Modifier GT: Via interactive audio and video telecommunications systems. This legacy modifier was historically used for Medicare telehealth claims but has been largely superseded by POS codes. Some payers may still require it.

Modifier GQ: Via asynchronous (store-and-forward) telecommunications system. Used for store-and-forward telehealth services, primarily in Alaska and Hawaii for Medicare purposes.

Modifier FQ: Telehealth service furnished using audio-only communication technology. Used in specific circumstances for RHCs and FQHCs.

(Sources: AAFP, "How to Code for Telehealth, Audio-Only, and Virtual- Digital Visits"; AAPC, "Telehealth 2025: The Final Rule"; CMS MLN901705)

E/M Code Selection for Telehealth ---

For Medicare, providers should use traditional office and outpatient E/M codes (99202-99215) for telehealth encounters. Medicare did NOT adopt the new telehealth-specific CPT codes 98000-98015 that were introduced by the AMA CPT Editorial Panel for 2025.

Key points:

- Use 99202-99215 with appropriate POS code (02 or 10) -- Add Modifier 93 for audio-only encounters -- Previous telephone E/M codes 99441-99443 were deleted effective

January 1, 2025

- Bill medical decision-making or time-based, same as in-person

(Sources: MGMA, "Understanding the 2025 telehealth CPT codes for video and audio-only visits"; Noridian Medicare, Article Detail on Telehealth E/M Services for 2025)

Brief Communication Services ---

CPT code 98016 was introduced in 2025 as the CPT-based equivalent of Medicare's G2012 for brief communication technology-based services. This covers quick audio or video check-ins between a provider and an established patient lasting 5 to 10 minutes. For dates of service on or after January 1, 2025, use 98016 instead of deleted HCPCS code G2012.

(Source: CMS Telehealth FAQ Calendar Year 2025)

Remote Patient Monitoring (RPM) Codes ---

RPM involves the use of non-face-to-face technology to collect and analyze physiological data such as blood pressure, blood glucose, oxygen saturation, and weight. Five current CPT codes apply:

CPT 99453 -- Remote monitoring setup and patient education

- One-time billing per patient per device -- Covers initial device setup and patient training

CPT 99454 -- Device supply and daily data transmission

- Billed monthly (once per 30-day period) -- Requires 16 device readings within the 30-day period

(Note: This 16-day requirement is being removed effective January 2026)

CPT 99457 -- First 20 minutes of RPM treatment management

- Requires real-time patient interaction (phone, video, or live chat)
- Billed per calendar month

CPT 99458 -- Each additional 20 minutes of RPM treatment management

- Same interaction requirements as 99457 -- Billed in addition to 99457

CPT 99091 -- Collection and interpretation of physiologic data

-- Requires minimum 30 minutes of data review per 30-day period -- Cannot be billed in same month as 99457/99458

Key RPM billing rules:

-- Only one practitioner can bill RPM per patient per 30-day period -- Patient consent is required at time RPM is furnished -- Devices must meet FDA medical device definition -- Data must be electronically collected and automatically uploaded -- RPM and RTM cannot be billed together for the same patient

(Sources: HHS Telehealth.gov, "Billing for remote patient monitoring"; ThoroughCare, "2025 Remote Patient Monitoring CPT Codes"; ACP Online, "Remote Patient Monitoring Billing, Coding and Regulations")

Remote Therapeutic Monitoring (RTM) Codes ---

RTM captures non-physiologic data related to therapeutic treatment, including musculoskeletal or respiratory system data, treatment adherence, and treatment response:

CPT 98975 -- RTM setup and patient education (one-time) CPT 98976 -- RTM device supply for respiratory system data CPT 98977 -- RTM device supply for musculoskeletal system data CPT 98978 -- RTM device supply for cognitive behavioral therapy CPT 98980 -- First 20 minutes RTM treatment management CPT 98981 -- Each additional 20 minutes RTM treatment management

RTM is distinct from RPM: RPM covers physiologic data (vital signs), while RTM covers therapeutic data (pain levels, medication adherence, exercise compliance).

(Source: Lara Health, "Remote Care Cheat Sheet: 2025 CPT Billing Codes")

Concurrent Billing Rules ---

RPM or RTM (but not both) may be billed concurrently with the following care management services, provided time is not double-counted:

-- Chronic Care Management (CCM) -- Transitional Care Management (TCM) -- Behavioral Health Integration (BHI) -- Principal Care Management (PCM) -- Chronic Pain Management (CPM)

(Source: CMS Telehealth and Remote Monitoring MLN901705, December 2025)

SECTION 7: THE VIRTUAL PHYSICAL EXAMINATION

Evidence, Techniques, and Limitations ---

The physical examination remains one of the most challenged aspects of telehealth delivery. Research provides important guidance on what can and cannot be reliably assessed remotely.

Evidence on Diagnostic Accuracy ---

A systematic review published in the Journal of Telemedicine and Telecare examined 61 studies comparing virtual physical examinations to in-person assessments. The virtual exam was considered

equivalent to in-person examination in 54 of these studies (89%) but was found to be inferior in 7 studies (11%).

A scoping review published in ScienceDirect (2024) identified the most commonly assessed virtual examination components:

- Neurologic examinations: 51% of studies -- Musculoskeletal examinations: 14% of studies -- Multi-system examinations: 8% of studies -- Neuropsychologic assessments: 7% of studies -- Skin/dermatologic examinations: 7% of studies

However, the review noted a wide range of interrater reliability across studies, indicating that diagnostic accuracy depends heavily on the specific examination component, technology quality, and patient cooperation.

(Sources: Liebertpub, "A Systematic Review of Physical Examination Components Adapted for Telemedicine," Telemedicine and e-Health; ScienceDirect, "Virtual physical examination in teleconsultation: A scoping review," 2024)

What Can Be Assessed Remotely ---

The following examination components have demonstrated reliability in virtual settings:

General Appearance and Vital Signs:

- General appearance, level of distress, nutritional status -- Patient self-measured vital signs (with home equipment):
 - blood pressure, heart rate, temperature, weight, oxygen saturation
- Respiratory rate (observed by provider)

Neurologic:

- Cranial nerve assessment (most components) -- Mental status examination -- Gait assessment (if adequate camera angle) -- Coordination testing (finger-to-nose, rapid alternating movements) -- Speech and language assessment -- Visual field testing (confrontation)

Musculoskeletal:

- Range of motion assessment (patient-directed) -- Gait analysis -- Posture and alignment -- Swelling, deformity, and erythema (visual) -- Patient-guided strength testing (with limitations)

Dermatologic:

- Skin lesion morphology and distribution -- Rash characterization -- Wound assessment (with adequate lighting and camera quality)

Psychiatric/Behavioral:

- Mental status examination -- Mood and affect assessment -- Psychomotor activity observation -- Thought process and content evaluation

(Sources: HHS Telehealth.gov, "Conduct a telehealth physical exam"; PMC, "The Telehealth Ten: A Guide for a Patient-Assisted Virtual Physical Examination," 2020)

What Cannot Be Reliably Assessed Remotely ---

The following examination components have significant limitations in virtual settings and may require in-person evaluation:

- Deep tendon reflexes (requires examiner or trained assistant) -- Pathologic reflexes (Babinski, Hoffman) -- Abdominal palpation (patient self-palpation has limited reliability) -- Cardiac auscultation (without digital stethoscope) -- Pulmonary auscultation (without digital stethoscope) -- Lymph node palpation -- Detailed joint examination (ligament stability testing) -- Rectal and pelvic examinations -- Ophthalmoscopy and otoscopy (without peripheral devices) -- Precise sensory testing

(Sources: PMC, "Physical Examination of the Spine Using Telemedicine: A Systematic Review," 2021; Springer, "A scoping review of the unassisted physical exam conducted over synchronous audio-video telemedicine," Systematic Reviews, 2022)

Documentation Strategies for Limited Examinations ---

When a complete physical examination is not possible via telehealth, providers should document:

- Which examination components were performed and findings -- Which components could not be performed and why -- Whether the limited examination was sufficient for clinical decision-making
- Whether an in-person follow-up is recommended specifically for physical examination purposes
- Any patient-assisted maneuvers that were attempted and their results

This documentation protects against audit challenges and malpractice claims by demonstrating that the provider recognized examination limitations and adapted the clinical approach accordingly.

SECTION 8: MALPRACTICE RISKS AND LIABILITY MITIGATION

An analysis by a US-based professional liability provider found that 66% of telemedicine-related claims between 2014 and 2018 were related to misdiagnosis. This is significantly higher than in-person consultations, where misdiagnosis accounts for approximately 47% of claims. Additionally, 60% of telehealth malpractice cases were settled or awarded to the plaintiff, with errors commonly found in documentation or triage.

(Source: PMC, "Digital health technology-specific risks for medical malpractice liability," 2022; PMC, "Reported Cases of Medical Malpractice in Direct-to-Consumer Telemedicine," 2019)

Primary Risk Categories ---

1. Diagnostic Error Due to Limited Examination

The inability to perform a complete physical examination is the single largest malpractice risk in telehealth. Cases have involved missed diagnoses of appendicitis, deep vein thrombosis, infections,

and neurological emergencies where visual and remote assessment proved insufficient.

Mitigation: Document examination limitations explicitly. Establish clear protocols for when to convert telehealth visits to in-person encounters. Document the clinical reasoning supporting management decisions despite examination limitations.

2. Inappropriate Prescribing Across State Lines

Most reported telemedicine malpractice cases historically involve physicians who prescribed medication across state lines without conducting in-person patient examinations. Courts have held that physician review of patient questionnaires submitted over the internet is insufficient to prescribe medication absent physical examinations verifying patients' health.

Mitigation: Maintain licensure in the patient's state. Follow DEA requirements for controlled substance prescribing. Document the clinical basis for prescribing decisions and the modality used for assessment.

3. Failure to Follow Up

A 2022 New York lawsuit alleged that the provider failed to follow up with a telehealth patient after prescribing opioids, violating both medical and regulatory standards. Telehealth visits may create a false sense of lower acuity, leading to inadequate follow-up.

Mitigation: Document follow-up plans with specific timeframes. Use automated appointment reminders. Document attempts to reach patients who do not follow up.

4. Inadequate Informed Consent

Poorly documented informed consent is a significant source of telehealth liability. This includes informed consent for telehealth as the modality (risks, benefits, alternatives, option for in-person care) and standard procedural or treatment informed consent. Inadequate and/or poorly documented informed consent can result in a claim for medical battery.

Mitigation: Use standardized telehealth consent processes. Document consent at or before the first telehealth encounter. Include specific language about telehealth limitations.

(Sources: National Law Review, "Is the Doctor In? Medical Malpractice Issues in the Age of Telemedicine"; Medscape, "3 Malpractice Risks of Video Visits"; PBG Law, "The Role of Telemedicine in Modern Medical Malpractice Cases")

5. Multi-State Jurisdiction Exposure

Physicians may face liability in the patient's state, where the physician may not be licensed and where different standards of care and malpractice laws apply. Patients may be required to file lawsuits in their own states, creating venue challenges for providers.

Mitigation: Confirm licensure in each state where patients are located. Understand malpractice laws in those states. Ensure malpractice insurance covers telehealth practice and all states where patients are seen.

6. Technology Failures

Technical failures during clinical encounters -- dropped video, poor audio quality, screen freezing during critical discussions -- create liability when clinical decisions are made despite inadequate

information transfer.

Mitigation: Document all technical issues that occur during encounters. Have protocols for when to reschedule versus continue with degraded technology. Never make critical clinical decisions based on poor-quality video assessment.

High-Risk Specialties for Telehealth Malpractice ---

- Mental Health: Difficulty following suicide prevention protocols remotely; inability to ensure patient safety during crisis
- Pediatrics: High prevalence of infections and rashes that are difficult to diagnose through a screen
- Emergency/Urgent Care: Time-sensitive conditions where delayed in-person evaluation may cause harm
- Dermatology: Image quality limitations affecting diagnostic accuracy

(Source: Montross Miller Law, "Telehealth Misdiagnosis Lawsuit: When it Becomes Medical Malpractice")

Insurance Considerations ---

Many providers assume their standard malpractice insurance covers telehealth services, but policies often contain exclusions. Providers should confirm with their insurance carriers that telemedicine risks are specifically covered, including multi-state practice if applicable.

(Source: American Bar Association, "Potential Legal Implications of Telemedicine and Telehealth," 2021)

SECTION 9: TECHNOLOGY REQUIREMENTS

HIPAA-Compliant Platforms, BAAs, and the FTC Health Breach Notification Rule ---

Technology infrastructure for telehealth must meet federal and state privacy requirements. Since HHS enforcement discretion for telehealth technology ended in 2023, full HIPAA compliance is mandatory.

HIPAA-Compliant Platform Requirements ---

Telehealth platforms must include:

- End-to-end encryption for all audio, video, and data transmission
- Unique user identification and authentication
- Two-factor authentication capability
- Automatic session timeout/logoff
- Audit controls and activity logging
- Access controls restricting information to authorized users
- Integrity controls to prevent unauthorized data alteration
- Transmission security (encrypted communication channels)
- Secure data storage for any recorded sessions or transmitted data

Platforms that are NOT HIPAA-compliant and should not be used for clinical telehealth include consumer-grade applications such as standard SMS text messaging, standard email without

encryption, social media platforms, and consumer video chat applications without BAAs (e.g., standard FaceTime, standard Skype, consumer Zoom without healthcare configuration).

(Source: HHS Telehealth.gov, "HIPAA rules for telehealth technology")

Business Associate Agreements (BAAs) ---

Any telehealth technology vendor that creates, receives, maintains, or transmits protected health information (PHI) on behalf of a covered entity is a business associate under HIPAA and must execute a Business Associate Agreement.

The BAA must include:

- Description of permitted uses and disclosures of PHI
- Agreement not to use or disclose PHI other than as permitted
- Requirement to implement appropriate safeguards
- Requirement to report breaches of unsecured PHI
- Agreement to ensure any subcontractors also comply
- Requirement to make PHI available to individuals upon request
- Requirement to make internal practices available to HHS for

compliance review

- Agreement to return or destroy PHI at termination

Providers should maintain copies of all BAAs and review them annually. Failure to execute a BAA with a telehealth platform vendor is itself a HIPAA violation, regardless of whether a breach occurs.

(Source: HHS.gov, HIPAA Business Associate requirements; AccountableHQ, "Telehealth and HIPAA Compliance for Providers in 2025")

FTC Health Breach Notification Rule ---

Since July 29, 2024, the updated FTC Health Breach Notification Rule significantly expanded its scope and requirements:

Covered Entities: The rule applies to vendors of personal health records and related entities NOT covered by HIPAA. This includes many consumer-facing health applications, wellness platforms, and direct- to-consumer telehealth tools.

Key Provisions:

- Unauthorized disclosures of health data are treated as "breaches" -- Entities must notify affected users without unreasonable delay

and within 60 calendar days

- The FTC must be notified directly if the breach affects 500 or more people

- Concurrent FTC notice is required for incidents affecting 500+ individuals

- Penalties for non-compliance are significant

Telehealth programs that operate consumer-facing applications must assess FTC Health Breach Notification Rule applicability alongside HIPAA requirements. Dual compliance may be necessary for organizations that operate both covered-entity clinical systems and consumer-facing health tools.

(Sources: FTC, "Complying with FTC's Health Breach Notification Rule"; Federal Register, "Health Breach Notification Rule," Document 2024-10855, May 30, 2024; HIPAA Vault, "What the FTC's New Health Breach Rule Means for Your HIPAA Strategy")

Security Risk Analysis ---

All telehealth implementations should include an updated security risk analysis that specifically addresses:

-- Telehealth-specific workflows and data flows -- Remote worker security (providers working from home) -- Patient-side security considerations -- Third-party vendor risks -- Network security for home-based providers -- Device management for telehealth equipment -- Incident response procedures specific to telehealth

SECTION 10: SPECIALTY-SPECIFIC TELEHEALTH DOCUMENTATION

Different clinical specialties have unique documentation requirements and considerations for telehealth delivery.

Mental Health and Behavioral Health ---

Telehealth has become the dominant modality for psychiatric and behavioral health services. Psychiatrists lead all specialties in telehealth adoption, with 85.9% reporting weekly video visits.

Documentation requirements specific to telepsychiatry:

Patient Location and Safety Assessment:

-- Document the patient's physical location at every session -- Assess and document the patient's environment for privacy

and safety

-- For patients with suicide risk, confirm and document the patient's exact address for emergency dispatch

Suicide Risk Assessment:

-- Assess suicide risk at every telehealth session -- Use validated screening tools: the Columbia-Suicide Severity

Rating Scale (C-SSRS) or Ask Suicide Screening Questions (ASQ)

-- Document collaborative safety planning using the Stanley-Brown

Safety Planning Intervention

- Document the patient's local emergency resources and crisis contacts
- Note that there is no evidence supporting the safety of complete remote management of actively suicidal patients; immediate face-to-face evaluation should be arranged when indicated

Crisis Protocols:

- Inform patients that in life-threatening emergencies, the clinician will call 911 and disclose necessary information
- Document that this protocol was explained to the patient -- Maintain a documented crisis plan for each patient, including local emergency contacts, nearby emergency departments, and the patient's home address

Mental Status Examination:

- Document observations of appearance, behavior, speech, mood, affect, thought process, thought content, cognition, insight, and judgment as observable via video
- Note any limitations in assessment due to technology -- Document psychomotor observations

(Sources: SAMHSA, "Telehealth for the Treatment of Serious Mental Illness," PEP21-06-02-001; Psychiatry.org, "Telepsychiatry Best Practices"; PMC, "Assessment of suicidal ideation via telemedicine: A case report and management suggestions," 2023; Zero Suicide, "Telehealth"; Relias, "Assessing Risk and Preventing Suicide via Telehealth")

Primary Care ---

Primary care telehealth documentation must balance comprehensive care with the limitations of remote assessment.

Key documentation elements:

- Chronic disease management parameters (blood pressure, glucose readings, weight) obtained via patient self-report or connected devices
- Preventive care and screening discussions -- Medication reconciliation and refill management -- Clear delineation of what was assessed virtually versus what requires in-person follow-up
- Referral coordination and care transition documentation -- Social determinants of health screening (which may be easier to observe in home-based visits)

For acute complaints, document the clinical reasoning supporting telehealth management versus

recommendation for in-person or emergency evaluation.

Dermatology (Teledermatology) ---

Teledermatology is one of the earliest telemedicine specialties, operational since 1995. Two primary modalities exist:

Store-and-Forward: Patients submit photographs through secure portals for asynchronous dermatologist review. Research shows this approach can screen and eliminate 70-80% of unnecessary in-person consultations.

Live Interactive: Real-time video consultation for dermatologic assessment.

(Source: AMA, "Telehealth scenario: Teledermatology")

Documentation requirements for teledermatology:

Image Documentation:

- The American Academy of Dermatology (AAD) recommends video cameras with minimum resolution of 800 x 600 pixels
- Document image quality and whether it was adequate for diagnosis -- Research shows 83% diagnostic concordance between in-person and digital photo diagnoses
- Patient-initiated images have lower and more variable diagnostic concordance (40-80%) compared to clinician-initiated images
- Document who captured the images and under what conditions

Clinical Documentation:

- Lesion location, size, morphology, color, and distribution -- Comparison with any prior images -- Assessment of whether image quality was sufficient for diagnosis or if in-person examination is needed
- Biopsy recommendations when visual assessment is insufficient -- Follow-up imaging timeline

(Sources: AAD Teledermatology Standards; PMC, "Store-and-Forward

Images in Teledermatology: Narrative Literature Review," 2022; PMC, "Teledermatology Diagnostic Accuracy: A Randomized Cohort Study Comparing Three Image Acquisition Techniques," 2025)

Cardiology ---

Telehealth cardiology increasingly incorporates remote monitoring alongside traditional video consultations.

Documentation requirements:

Remote Monitoring Integration:

- Document data from connected devices (blood pressure monitors, weight scales, pulse oximeters, implantable cardiac devices)
- Record alert responses with clinical reasoning -- FDA-approved Alert Management Guides should direct response
 - protocols for implantable device alerts
- Document whether alerts required patient contact, medication changes, urgent visits, or observation with rationale

Heart Failure Management:

- Daily weight trends and fluid status assessment -- Symptom progression or improvement -- Medication titration documentation with remote monitoring data -- Threshold parameters that would trigger in-person evaluation -- Integration of multidisciplinary team input (nurses, advanced practice providers, device representatives)

Cardiac Rehabilitation:

- Exercise tolerance and adherence documentation -- Remote monitoring data during supervised exercise sessions -- Symptom monitoring and safety parameters

(Sources: JACC, "Remote Monitoring for Heart Failure Management at

Home: JACC Scientific Statement," 2023; PMC, "Remote monitoring and telemedicine in heart failure: implementation and benefits," 2021; European Heart Journal Supplements, "Remote monitoring and heart failure," 2025)

SECTION 11: QUALITY METRICS AND OUTCOMES

Telehealth vs. In-Person Care ---

A comprehensive body of evidence now exists comparing telehealth and in-person care across multiple dimensions.

Clinical Outcomes ---

A 2024 systematic review published in npj Digital Medicine compared telehealth with in-person care using data from 77 studies conducted between March 2020 and April 2023. Key findings:

- Differences in healthcare utilization and clinical outcomes
 - between in-person and telehealth care were generally small and/or not clinically meaningful
- Telehealth was comparable to in-person care across different
 - clinical areas and different healthcare utilization, clinical, and process outcomes
- The majority of studies (61%) had serious or high risk of bias,
 - limiting definitive conclusions

(Source: Greenhalgh T, et al. "Effectiveness of telehealth versus in-person care during the COVID-19 pandemic: a systematic review." npj Digital Medicine, 2024)

A broader meta-analysis examining telehealth modalities across multiple specialties found:

- Telehealth significantly reduces all-cause hospitalizations by
18 fewer hospitalizations per 1,000 patients
- Condition-related hospitalizations reduced by 37 fewer per
1,000 patients
- Telehealth showed clinical equivalence or superiority in
cardiovascular disease, dermatology, endocrinology, neurology, nephrology, obstetrics,
ophthalmology, psychiatry, psychology, pulmonary, and multidisciplinary care

(Source: PMC, "The Impact of Telehealth Adoption on Patient Outcomes: A Systematic Review," 2025)

Patient Satisfaction ---

Systematic reviews consistently show high patient satisfaction with telehealth encounters:

- Video visits had the highest mean satisfaction scores across
all domains
- Patients reported significantly higher satisfaction for access
measures with telehealth visits compared to in-person visits ($p < 0.001$)
- Overall satisfaction levels were high across multiple studies
and settings

(Source: PMC, "Patient Satisfaction with Telemedicine during the COVID-19 Pandemic -- A Systematic Review," 2022)

Appointment Adherence and No-Show Rates ---

One of the most robust findings in telehealth research is the reduction in missed appointments:

- In one study, in-office missed appointment rate was 36.1%
compared to the telehealth no-show rate of 7.5%
- A meta-analysis found reduced likelihood of non-attendance
in patients receiving virtual care compared to in-person groups (OR = 0.61)
- Analysis of 412,415 appointments across a major US medical
system (2020-2022) showed telehealth reduced no-shows by 3.0 percentage points (23.1%
reduction) and late arrivals by 11.4 percentage points (35.6% reduction)
- Telehealth was particularly effective for follow-up appointments

but may be less suitable for initial consultations

(Sources: Drerup B, et al. "Reduced No-Show Rates and Sustained Patient Satisfaction of Telehealth During the COVID-19 Pandemic." Telemedicine and e-Health, 2021; BMC Health Services Research, "Systematic review and meta-analysis of no show or non-attendance rates among telehealth and in-person models of care," 2025; Kamalahmadi M, et al. "Breaking Barriers: Improving Patient Adherence to Appointments." SAGE Journals, 2025)

Health Equity Impact ---

Research shows telehealth improves appointment adherence most among demographic groups with historically lower in-person attendance:

- Women -- Racial minorities -- Medicaid patients -- Younger adults

This finding underscores telehealth's potential to reduce disparities in access to care, though digital divide concerns remain for populations without reliable internet access or technological literacy.

(Source: Kamalahmadi M, et al. "Breaking Barriers." SAGE Journals, 2025)

Limitations of Current Evidence ---

Providers should note important limitations:

- Most comparison studies occurred during the pandemic, when in-person care was disrupted
- Limited randomized controlled trial data exists -- Heterogeneous study designs and outcomes make meta-analysis difficult
- Long-term outcomes data for telehealth-managed conditions remains limited
- Selection bias exists: patients choosing telehealth may differ systematically from those choosing in-person care

SECTION 12: PATIENT CONSENT

State-by-State Requirements ---

Forty-five states, the District of Columbia, and Puerto Rico include some form of telehealth consent requirement in their statutes, administrative codes, and/or Medicaid policies. Requirements vary significantly.

Federal Requirements ---

CMS does not require that providers obtain specific informed consent for Medicare telehealth services prior to delivering care. However, many states impose consent requirements within their Medicaid programs or for all healthcare providers delivering telehealth services.

(Source: CMS Telehealth FAQ; CCHP, "States with Telehealth Consent Requirements")

Categories of State Requirements ---

States generally fall into these categories:

Written or Digital Consent Required: Some states require signed consent forms (paper or electronic) before telehealth services can be delivered. These typically require the patient's signature and acknowledgment of specific disclosures.

Verbal Consent Accepted: Many states accept verbal consent as long as it is documented in the provider's notes. The provider should document that verbal consent was obtained, including the date and specific disclosures made.

No Specific Telehealth Consent Required: A small number of states do not have separate telehealth consent requirements beyond standard informed consent for medical treatment.

Specific State Examples:

- California: Requires explicit documentation of telehealth consent in the patient's medical record
- Texas: Mandates that providers inform patients of their rights, including the option to decline telehealth in favor of in-person care
- Delaware: Requires informed consent to treat via telemedicine but does not require written consent
- Maine (Optometry Board): Requires informed consent for telehealth services to be documented in the telehealth record in a timely manner

(Sources: CCHP, "States with Telehealth Consent Requirements"; Mend, "Informed Consents for Telemedicine: What To Know In Your State"; HHS Telehealth.gov, "Obtaining informed consent")

Recommended Consent Elements ---

Regardless of specific state requirements, best practice telehealth consent documentation should address:

- The nature of telehealth and how it differs from in-person care -- Potential benefits (convenience, access, reduced travel) -- Potential risks and limitations (technology failures, limited physical examination, privacy risks)
- The patient's right to refuse telehealth and receive in-person care instead
- How the patient's health information will be protected -- The technology platform being used -- What will happen in case of a technology failure during a visit -- Emergency procedures if the patient requires immediate

in-person attention

-- Billing and cost information, including any differences from

in-person visit costs

-- Recording policies (whether the session may be recorded) -- Who may be present during the visit (on both ends)

The most current and detailed state-by-state requirements are maintained by the Center for Connected Health Policy (CCHP) in their State Telehealth Laws and Reimbursement Policies Report, updated Fall 2025.

(Source: CCHP State Telehealth Laws and Reimbursement Policies Report, Fall 2025)

SECTION 13: IMPLEMENTATION CHECKLIST FOR PROVIDERS

Use this checklist when establishing or auditing a telehealth program.

Licensure and Credentialing ---

- ☐ Verify licensure in every state where patients are located
- ☐ Evaluate IMLC or compact eligibility if practicing across states
- ☐ Confirm credentialing with payers for telehealth services
- ☐ Maintain DEA registration compliance for controlled substances
- ☐ Review state-specific telehealth practice standards

Technology and Privacy ---

- ☐ Select a HIPAA-compliant telehealth platform
- ☐ Execute a Business Associate Agreement with the platform vendor
- ☐ Implement end-to-end encryption for all communications
- ☐ Enable two-factor authentication for provider accounts
- ☐ Establish secure backup communication methods for technology failures
- ☐ Conduct and document a security risk analysis
- ☐ Evaluate FTC Health Breach Notification Rule applicability
- ☐ Train staff on telehealth privacy and security protocols

Documentation Templates ---

- ☐ Create telehealth-specific note templates with required elements
- ☐ Include fields for: modality, patient location, provider location, consent, technology quality, and emergency contact information
- ☐ Develop audit-ready documentation checklists
- ☐ Integrate with existing EHR workflows

Billing and Coding ---

- ☐ Verify correct POS codes (02 vs 10) in billing workflows
- ☐ Confirm modifier usage (93 for audio-only, 95 for commercial payers)
- ☐ Update charge capture systems for telehealth encounters
- ☐ Train billing staff on telehealth-specific coding rules
- ☐ Implement RPM/RTM billing workflows if applicable
- ☐ Verify payer-specific telehealth policies (each payer may differ)

Clinical Protocols ---

- ☐ Establish criteria for telehealth-appropriate visits vs. in-person
- ☐ Create protocols for converting telehealth to in-person when needed
- ☐ Develop virtual physical examination procedures by complaint type
- ☐ Implement suicide risk assessment protocols for behavioral health
- ☐ Create emergency response procedures for patient crises
- ☐ Document follow-up procedures and safety nets

Patient Engagement ---

- ☐ Develop patient education materials for telehealth visits
- ☐ Create pre-visit technology check procedures
- ☐ Implement consent processes compliant with applicable state laws
- ☐ Provide patients with emergency contact information for their location
- ☐ Establish processes for collecting patient-reported data

Quality and Compliance ---

- ☐ Monitor telehealth documentation completeness through regular audits
- ☐ Track patient satisfaction with telehealth encounters
- ☐ Review no-show rates comparing telehealth and in-person visits
- ☐ Monitor claim denial rates for telehealth services
- ☐ Stay current with CMS, DEA, and state regulatory changes
- ☐ Verify malpractice insurance covers telehealth across all states

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