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NOTES

HOOSIERS LEADING THE WAY: PRESCRIBING NON-OPIOID CONTROLLED SUBSTANCES VIA TELEMEDICINE

CARAH J. AUSTIN*

“My dear doctor, I’m surprised to hear you say that I am coughing very badly, because I have been practicing all night.” John Philpot Curran.¹

I. INTRODUCTION

A. The Issue

Persistent coughing, high fever, and congestion—these are typical indicators that someone is inflicted with the flu or a similar illness.² When James, a resident of Indiana, was experiencing these symptoms, and therefore in need of a doctor’s opinion and a possible prescription to alleviate his ailments, he did not go the typical route of doing so.³ He did not have to get dressed up or drive the many miles to and from the urgent care and pharmacy.⁴ He did not have to spend the hours that it would take to see a provider and get his prescription.⁵ In fact, James did not even have to leave his home.⁶ Instead, James turned on his computer in the comfort of his own home and called a local doctor through the innovative service that is telemedicine.⁷

The creation of internet services, such as Skype, FaceTime, and Google Hangouts, allow people to converse as if in person but without having to actually be in the same proximity.⁸ While this type of communication is great for college students wanting to see their parents or pets back home, the foundational basics

* J.D. & M.H.A. Candidate, 2020, Indiana University Robert H. McKinney School of Law; B.S., 2016, Butler University.

1. DES MACHALE, WIT 162 (2003).

2. *Do You Have a Cold or Flu?*, WEBMD, <https://www.webmd.com/cold-and-flu/flu-guide/is-it-cold-flu> [<https://perma.cc/C2HD-ANHC>].

3. Interview with James Rochester, Resident, Camby, Ind. (Dec. 20, 2017).

4. *Id.*

5. *Id.*

6. *Id.*

7. *Id.*

8. See Lewis Wake, *Skype vs FaceTime vs Google Hangouts*, UNIV. ST. ANDREWS (Sept. 26, 2016), <https://digitalcommunications.wp.st-andrews.ac.uk/2016/09/26/skype-vs-facetime-vs-google-hangouts/> [<https://perma.cc/PS79-G2PV>].

behind video-communications programs have great implications in the ever-evolving and technology-dependent world of health care. In fact, popping up across Indiana recently are billboards and radio ads promoting this fairly modern method of health care delivery—the same advancement in health care delivery that James used to combat his cold: telemedicine.

Many major Indiana providers have recently been swapping out in-person patient visits with videoconferencing. Indiana hospital networks, such as Franciscan Health (“Franciscan”),⁹ Indiana University Health (“IU Health”),¹⁰ and Community Health Network (“CHN”),¹¹ have rolled out their own versions of a convenient virtual office visit. This Note will use these three providers as the basis for the following case study on Indiana telehealth services. For most networks, telemedicine is as simple as creating a patient account online or registering via the provider’s telehealth app, completing the patient’s medical history, and scheduling a virtual care visit.¹²

With the ever-changing field of health care now expanding into telemedicine services, it is more important than ever for lawmakers to consider the importance of a health care provider’s ability to legally prescribe medications to their online patients so as to treat them as effectively as possible. The Indiana Code, for example, has been amended twice (in 2016 and 2017) to lessen the restrictions on physicians’ online prescribing abilities.¹³ This is good news for Indiana providers and patients alike. As will be discussed in this Note, telemedicine results in decreased cost and increased access to health care services, and with better access to their “toolkit” (i.e., prescription medications), Indiana telehealth providers will be able to more efficiently and effectively treat their patients.

Many non-opioid controlled substances are an effective tool in treating illness and the option to prescribe these substances should be available to telemedicine providers. Although in light of the recent opioid epidemic physicians need to be vigilant about their prescription of opioids, a middle ground needs to be paved so that telemedicine providers can recommend the best treatment option for their virtual patients. This Note will argue that Indiana’s recent changes to its telemedicine prescribing laws allow providers the toolkit necessary to treat their telemedicine patients. This Note will also suggest that Indiana’s updated telemedicine prescribing laws provide a respectable middle ground between provider autonomy and the regulation of controlled substances. This Note recommends that the recent changes in Indiana’s telemedicine prescribing laws should be mirrored by other states.

9. *Telehealth*, FRANCISCAN HEALTH, <https://www.franciscanhealth.org/health-care-services/telehealth-377> [<https://perma.cc/C25B-6WN6>].

10. *IU Health Video Visits*, IND. U. HEALTH, <http://iuhealth.org/videovisitsapp/> [<https://perma.cc/9KP5-9VTT>].

11. *Community Virtual Care*, MDLIVE, https://members.mdlive.com/ecommunity/landing_home [<https://perma.cc/T9XJ-NXVG>].

12. *Id.*

13. It is possible that the Indiana Code will continue to be amended in coming years to further address the technological changes in medicine delivery.

B. Roadmap

This Note will first provide a 30,000-foot overview of the United States (“U.S.”) health care system, focusing specifically on the cost of and access to health care services. Section II will discuss the background, various definitions, and history of telemedicine. It will also explore the types of providers and consumers of telemedicine, health issues that can be addressed by telemedicine, and the HIPAA and cybersecurity issues involved with providing medical treatment virtually. Finally, Section II will look at the positive impacts of telemedicine on the health care system, focusing specifically on decreased cost to the system and the provider and increased access to health services.

Next, Section III will examine the medical standard of care and analyze cases in which providers toed the line of what was and was not allowed in online prescribing. Particularly, controlled substances and opioids will be the focus. This Section will then explore the regulation of telemedicine prescribing practices by entities such as individual telemedicine providing organizations, the American Medical Association (“AMA”), federal regulations, and state regulations. Additionally, Section III will look at the recent changes that have been made to Indiana’s telemedicine prescribing laws, particularly House Enrolled Act 1263 in 2016, and House Enrolled Act 1337 in 2017. Indiana’s laws will then be compared to other states’ telemedicine prescribing laws in terms of restrictiveness.

Finally, in Section IV, this Note will conclude that hospitals offering telemedicine services will increase access to care for their served communities and will decrease their expenditures on health care services (primarily for urgent/primary care). It will be suggested that Indiana is leading the way in telemedicine prescription laws and other states should amend their regulations to be in line with Indiana. Additionally, it will be recommended that individual providers and the AMA should also amend their guidelines to catch up with recent legislation while also offering providers a clear guideline of the standard of care that.

II. U.S. HEALTH CARE ACCESS AND COST AS IT RELATES TO TELEMEDICINE

A. 30,000-foot Overview of the U.S. Health Care System

The golden rule of health care in our society is that everyone deserves the finest health care attainable, provided someone else pays. But in what I call the iron triangle of health care, access, quality, and cost containment have equal angles, representing identical priorities, and an expansion of any one angle compromises one or both of the other two. All societies confront the equal tensions among access to health services, quality of health care, and cost containment. Tradeoffs are inevitable regardless of the size of the triangle. Call them resource allocation or rationing, they

are choices our society must make.¹⁴

The major aims of the Affordable Care Act (“ACA”) were to address two sides of the iron triangle: make health care more affordable and improve access to health care.¹⁵ Telemedicine works to not only lower the cost of ambulatory and long-term health care, but to also increase access to care. While the ACA implemented telemedicine coverage at the federal level through Medicare, it mainly left the decision of what telemedicine services would be covered under Medicare to the states.¹⁶ First, to understand the impact that telemedicine has on health care cost and access, a brief overview of the current fiscal and access conditions in American health care is necessary.

1. Cost

In 2015, the U.S. spent \$3.2 trillion (roughly \$9,990 per person) on health care.¹⁷ This is an astonishing amount compared to other developed countries. For example, in 2014, Canada spent only \$4,506 per person on health care with the United Kingdom spending a mere \$3,971 per person.¹⁸ Additionally, in the U.S., spending on physician and clinical services increased by 6.3% between 2014 and 2015, and spending for hospital care increased by 5.6%.¹⁹ National Health Expenditure accounted for 17.8% of the Gross Domestic Product in 2015 in the U.S.,²⁰ while health expenditure only accounted for 10.4% in Canada and 9.1% in the United Kingdom.²¹ While the U.S. far outspends its counterparts in terms of health care, where does Indiana stand within the U.S.’ extreme spending habits?

Indiana ranks as the 15th highest spender on health care services, spending

14. WILLIAM L. KISSICK, *MEDICINE’S DILEMMAS: INFINITE NEEDS VERSUS FINITE RESOURCES* 2 (1994).

15. See *Access to Quality, Affordable Health Care: Progress and Promise of the Affordable Care Act and Other Administration Efforts*, WHITE HOUSE, (Oct. 20, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/10/20/access-quality-affordable-health-care-progress-and-promise-affordable> [<https://perma.cc/WBQ3-CF6A>].

16. Y. Tony Yang, *Telehealth Parity Laws*, HEALTH AFF., (Aug. 15, 2016) <https://www.healthaffairs.org/doi/10.1377/hpb20160815.244795/full/> [<https://perma.cc/SBR9-A2BZ>].

17. *National Health Expenditures 2015 Highlights*, CTRS. FOR MEDICARE & MEDICAID SERVICES, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>, [<https://perma.cc/T3Z7-KU8R>].

18. *United States Per Capita Healthcare Spending is More Than Twice the Average of Other Developed Countries*, PETER G. PETERSON FOUND. (2016), https://www.pgpf.org/sites/default/files/0006_health-care-oecd.pdf [<https://perma.cc/PP76-NALX>].

19. *National Health Expenditures 2015 Highlights*, *supra* note 17.

20. *Id.*

21. *Health Expenditure, Total (% GDP)*, WORLD HEALTH ORG. GLOBAL HEALTH EXPENDITURE, <https://data.worldbank.org/indicator/SH.XPD.TOTL.ZS> [<https://perma.cc/4TXL-Z9HT>].

roughly \$54 billion on health care services in 2014,²² and spending \$8,300 per capita on health care costs, a category in which the Hoosier state ranks 22nd.²³ Indiana also ranks 16th in terms of the average annual percent growth in health care expenditure between 1991 and 2014, at 5.3% per year.²⁴ Although Indiana is not as much to blame for the country's massive health care expenditure as the number one per capita spender—the District of Columbia at \$11,944 per person—improving the costs associated with the health care system is always possible.²⁵

2. Access

According to the Institute of Medicine, access to health services means “the timely use of personal health services to achieve the best health outcomes.”²⁶ Access to health services is important because it impacts an individual's overall physical, social, and mental health status and quality of life.²⁷ Unfortunately, there are still many barriers to accessing health services in the U.S.²⁸ Some of these barriers include high cost of care, inadequate or no insurance coverage, lack of availability of services, and lack of culturally competent care.²⁹ These barriers ultimately lead to unmet health needs, delays in receiving appropriate care, inability to receive preventive services, financial burdens, and avoidable hospitalizations.³⁰

A particular barrier that the U.S. struggles with is its physicians per capita. In 2015, the U.S. had an average of just 2.5 physicians per 100,000 people, whereas other developed countries, such as Germany (4.0) and Greece (6.2), far outranked the U.S.³¹ Indiana struggles with this barrier as well. In 2015, Indiana

22. *Health Care Expenditures by State of Residence (in Millions)*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/health-care-expenditures-by-state-of-residence-in-millions/> [<https://perma.cc/GW7C-3H8E>].

23. *Health Care Expenditures per Capita by State of Residence*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Health%20Spending%20per%20Capita%22,%22sort%22:%22desc%22%7D> [<https://perma.cc/RR2H-QW2M>].

24. *Average Annual Percent Growth in Health Care Expenditures per Capita by State of Residence*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/avg-annual-growth-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Avg.%20Annual%20%25%20Growth%20per%20Capita%22,%22sort%22:%22desc%22%7D> [<https://perma.cc/RF4K-MY6Q>].

25. *Health Care Expenditures by State of Residence (in Millions)*, *supra* note 22.

26. INST. OF MED., *ACCESS TO HEALTH CARE IN AMERICA* (Michael Millman ed., 1993).

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.*

31. MERRITT HAWKINS, *THE PHYSICIAN SHORTAGE: DATA POINTS AND STATE RANKINGS 9* (2015).

ranked 36 in the country with 205.7 physicians per 100,000 people.³² Comparatively, the number one ranked state, Massachusetts, maintains a rate of 349.5 physicians per 100,000 patients.³³ Indiana also ranked 37 in the category of primary care physicians per 100,000 people with 74.1 doctors.³⁴ Not surprisingly, as a result 77.8% of Indiana physicians reported being at capacity or overextended.³⁵

Specifically, access to health care in rural settings is a significant barrier in Indiana. Access to physicians across Indiana is inequitably distributed, mainly due to poor performance in recruitment and retention of active providers in rural areas.³⁶ In the U.S., only 9% of physicians practice in rural areas despite 20% of the population residing in rural settings and 60% of Indiana counties resting in rural or non-metropolitan areas.³⁷ In 2012, Marion County, an urban community,³⁸ was rated as the top Indiana county in terms of physician access.³⁹ In contrast, counties with a more rural make-up, such as Posey and Switzerland County,⁴⁰ were rated as having the worst access to physician care.⁴¹ This is primarily due to the shortage of health professionals in rural communities.⁴² In 2015, urban communities, on average, were found to have a rate of 70 primary care physicians, 60 dentists, 184 mental health providers, and 1,040 registered nurses per 100,000 people.⁴³ Rural areas, however, were found to have a rate of only 43 doctors, 31 dentists, 55 mental health providers, and 453 registered nurses per 100,000 residents.⁴⁴

As the U.S., including Indiana, faces health care issues such as cost of care

32. *Id.* at 3.

33. *Id.*

34. *Id.* at 5.

35. *Id.* at 14.

36. AFFILIATED SERV. PROVIDERS OF IND., INC., INDIANA STATE RURAL HEALTH PLAN (2012), https://www.in.gov/isdh/files/Indiana_State_Rural_Health_Plan_2012.pdf [<https://perma.cc/976J-LW83>].

37. NAT'L RURAL HEALTH ASS'N, *Recruitment and Retention of a Quality Health Work Force in Rural Areas* (Nov. 2006), <https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents/RR6publicHlth.pdf.aspx?lang=en-US> [<https://perma.cc/4HMY-USXS>].

38. In July 2016, the population of Marion County, Indiana was estimated to be 941,229 people. *QuickFacts*, U.S. CENSUS BUREAU, <https://www.census.gov/quickfacts/fact/map/marioncountyindiana/PST045216#viewtop>.

39. AFFILIATED SERV. PROVIDERS OF IND., INC., *supra* note 36.

40. In July 2016, the population of Posey County and Switzerland County, Indiana were estimated to be 25,476 and 10,527 respectively. *QuickFacts*, U.S. CENSUS BUREAU (last visited Feb. 19, 2018), <https://www.census.gov/quickfacts/fact/map/marioncountyindiana/PST045216#viewtop>.

41. AFFILIATED SERV. PROVIDERS OF IND., INC., *supra* note 36.

42. *Id.*

43. IND. UNIV. PUB. POLICY INST., *Hoosier Health and Access to Care*, (2015), http://policyinstitute.iu.edu/Uploads/PublicationFiles/Hoosier%20health_Thriving__web.pdf [<https://perma.cc/6GRX-AEV5>].

44. *Id.*

and access to care, health care providers have begun to use advances in social technology to provide health care in an easier and more efficient manner.

B. Telemedicine Background

1. Telemedicine Defined

Telemedicine has been given a variety of definitions, from layman terms used by the everyday patient to organizational definitions provided by health care organizations to the definition in statutes created by legislatures. According to the American Telemedicine Association (“ATA”), “[t]elemedicine is the remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite and telephone media.”⁴⁵ While some organizations provide distinctive descriptions for each word, “ATA treats ‘telemedicine’ and ‘telehealth’ as synonyms and uses the terms interchangeably.”⁴⁶ Both terms have the synonymous meaning of delivering clinical services remotely through health care technology.⁴⁷

The U.S. Code defines the practice of telemedicine as

the practice of medicine in accordance with applicable Federal and State laws by a practitioner (other than a pharmacist) who is at a location remote from the patient and is communicating with the patient, or health care professional who is treating the patient, using a telecommunications system.⁴⁸

Most important to the substance of this Note, the Indiana Code defines telemedicine as the delivery of health care services using electronic communications and information technology, including: (1) secure videoconferencing; (2) interactive audio-using store and forward technology; or (3) remote patient monitoring technology; between a provider in one (1) location and a patient in another location.⁴⁹ It is also important to note that the Indiana legislature does not include in the term the following: (1) audio-only communication; (2) a telephone call; (3) electronic mail; (4) an instant messaging conversation; (5) facsimile; (6) internet questionnaire; (7) telephone consultation; or (8) internet consultation.⁵⁰

45. *About Telemedicine*, AM. TELEMEDICINE ASS’N, <http://www.americantelemed.org/about/telehealth-faqs-> [<https://perma.cc/7VK3-L7ZT>].

46. *Id.* As the ATA treats telemedicine and telehealth as one in the same, and Indiana statutory language does not specify a difference either, this Note will use the two terms synonymously.

47. *Id.*

48. 21 U.S.C.S. § 802 (54) (2017).

49. IND. CODE § 25-1-9.5-6 (2016).

50. IND. CODE § 25-1-9.5-6 (2016).

2. History

The rudimentary idea behind telemedicine—delivering health care information across some sort of continuum—reaches back to ancient Greece and Rome.⁵¹ Many communication mechanisms, including smoke signals and light reflections, were used to communicate medical information, such as the outbreak of a plague and notifications of births and deaths.⁵² Modern telemedicine began with the invention of the telegraph and telephone, which brought long distance communication to the public.⁵³ In April 1924, an issue of *Radio News* magazine published an image of a patient and a physician using a monitor and a microphone for means of communicating about the heartbeat and temperature of the patient.⁵⁴ Although this was merely an image of the imagination at the time, the idea of transmitting medical information via non-face-to-face methods was gaining traction.⁵⁵ In the 1950s and 1960s, the University of Nebraska used the concept of telemedicine to conduct neurological examinations using medical data such as fluoroscopy images, x-rays, and electrocardiograms.⁵⁶ One of the University's motivations in conducting telemedicine services was to provide access to health care in rural areas.⁵⁷ The rise of the internet in the 1990s brought along the basis for telemedicine as we know it today.⁵⁸ The internet allowed providers to deliver patient education, view medical images, conduct real-time audio and video consultations, and measure vital signs all via the internet.⁵⁹ Today, as will be discussed further in this Note, patients and providers have a plethora of technological services available to receive and provide medical care, such as smartphone cameras, vital sign monitoring devices, digital stethoscopes, and so on.⁶⁰

3. Prescribers

Indiana Telemedicine laws define prescribers as any of the following:

- (1) a physician licensed under IC 25-22.5;
- (2) a physician assistant licensed under IC 25-27.5 and granted the authority to prescribe by the physician assistant's supervisory physician in accordance with IC 25-27.5-5-4;

51. *History of Telemedicine*, MDPORAL, <http://mdportal.com/education/history-of-telemedicine/> [https://perma.cc/7XXF-35NW].

52. *Id.*

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*

- (3) an advanced practice nurse licensed and granted the authority to prescribe drugs under IC 25-23;
- (4) an optometrist licensed under IC 25-24; and
- (5) a podiatrist licensed under IC 25-29.⁶¹

Under Indiana law, those certified in the above professions in the state of Indiana can provide a medical consultation and prescription if warranted through a telemedicine service. Three of Indiana's major health care providers, Franciscan, IU Health, and CHN, provide some form of telemedicine service.⁶² CHN, although located in Indiana, provides telehealth services that are available anywhere in the U.S. with a few state specific exceptions.⁶³ CHN's providers are all U.S. Board Certified and fully licensed to practice medicine in the state the patient is located.⁶⁴ To ensure that CHN providers are meeting their patients' needs, patients are given a survey to evaluate their providers and appointments.⁶⁵ CHN analyzes and reviews the results for quality assurance and uses them as part of their continuous improvement process.⁶⁶ "Selected provider consultations are also reviewed by [their] internal medical board."⁶⁷

Likewise, IU Health has expanded their access to health care through its telemedicine program, "Video Visits", which provides services to anyone in Indiana.⁶⁸ When using IU Health's services, a patient will connect "with a highly skilled IU Health or IU Health affiliated physician."⁶⁹ Similarly, patients will meet with a board-certified Franciscan Health physician via the internet, if choosing to go through Franciscan to receive telemedicine services.⁷⁰ In short, in order to provide telemedicine services a provider must fall into one of the categories as described by the Indiana Code. The three Indiana telemedicine services that this Note analyzes all ensure that their providers are licensed to practice medicine in the state of Indiana.

61. IND. CODE § 25-1-9.5-4 (2017).

62. While this is not an exhaustive list of providers that offer telemedicine services to Indiana residents, this Note will use these three providers to give an overview of typical telemedicine practices.

63. *Community Virtual Care Frequently Asked Questions*, MDLIVE, https://members.mdlive.com/ecomunity/how_it_works [<https://perma.cc/37UR-PM2M>]. Community Health Network does not specify any exceptions for patients residing in Indiana.

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.*

68. *IU Health Expands Access to Health Care with Video Visits*, HENDRICKS COUNTY FLYER, http://www.flyergroup.com/news/local_news/iu-health-expands-access-to-health-care-with-video-visits/article_98fafb22-ba80-510a-9874-6fe2144e5751.html [<https://perma.cc/HQN5-RCHP>].

69. *Id.*

70. *Franciscan on Demand*, FRANCISCAN HEALTH, <https://www.franciscanhealth.org/FranciscanOnDemand> [<https://perma.cc/SBM7-82K4>].

4. Consumers

Typically, any patient who would be able to utilize an urgent care facility to receive treatment can use a telemedicine service. Adults and children two-years and older in Indiana can see a provider via the IU Health Video Visits⁷¹ while Franciscan Health allows anyone twelve-years and older to conduct a virtual visit.⁷²

5. Health Issues Addressed

Most organizations offering telemedicine services have 24/7 availability for patients to discuss with a provider common conditions that one would usually go to an urgent care facility to treat.⁷³ Conditions commonly treated by telehealth services include colds, minor rashes, allergies, flu, headache, insect bites, respiratory problems, and acne.⁷⁴

In addition to urgent care situations, telehealth is also used for scheduled visits in which a patient can talk with a provider about more long-term illnesses and conditions, such as weight management, depression, dermatology, and diabetes.⁷⁵

Telehealth also seeks to reduce some of the inefficiencies of home health care in various ways, including replacing certain nursing visits with video appointments, collecting vital-signs data remotely, and improving medication compliance and patient education. The use of telehealth in home health care settings will provide a means of interacting in a patient-centered manner, promoting patient autonomy through education, and improving communication.

One of the substantial benefits stemming from telehealth services is the access to prescriptions without having to worry about the traffic, time, and money associated with visiting a doctor in person. Providers via IU Health's Video Visits, for example, can send a prescription directly to a patient's pharmacy of choice. However, these providers do not prescribe controlled substances.⁷⁶ Similarly, if a CHN telemedicine provider believes medication is necessary, a prescription for a non-controlled substance can be sent electronically to over 65,000 pharmacies.⁷⁷ The latter part of this Note will further address the access to and regulation of prescription drugs via telemedicine services in Indiana.

71. *IU Health Video Visits Frequently Asked Questions*, IND. U. HEALTH, <http://iuhealth.org/videovisitsfaqs/> [<https://perma.cc/5SGG-PUCL>].

72. *Franciscan on Demand*, *supra* note 70.

73. *IU Health Video Visits*, *supra* note 10.

74. *Franciscan on Demand*, *supra* note 70; *Community Virtual Care Frequently Asked Questions*, *supra* note 63.

75. *IU Health Video Visits*, *supra* note 10.

76. *IU Health Video Visits Frequently Asked Questions*, *supra* note 71; *see Drug Schedules I-5*, IND. STATE DEP'T HEALTH, <https://www.in.gov/isdh/27380.htm> [<https://perma.cc/SG56-442V>] (listing controlled substances in Indiana).

77. *Community Virtual Care Frequently Asked Questions*, *supra* note 63.

6. HIPAA and Security

Just as with any health services provided in-person, Health Insurance Portability and Accountability Act (“HIPAA”) guidelines are binding on medical providers who practice via telemedicine and provide services in the home of the patient.⁷⁸ Providers must keep in mind that the channel of communication used for communicating electronic protected health information (“ePHI”) at a distance is also important in complying with HIPAA guidelines.⁷⁹ The HIPAA guidelines on telemedicine state: “(1) only authorized users should have access to ePHI; (2) a system of secure communication should be implemented to protect the integrity of ePHI; and (3) a system of monitoring communications containing ePHI should be implemented to prevent accidental or malicious breaches.”⁸⁰

Specific policy language varies by organization, but all must ensure, at the least, to meet patient privacy laws. For example, CHN assures that Community Virtual Care is safe and private.⁸¹ CHN’s telemedicine services are compliant with HIPAA and patient information will only be shared with the selected provider and pharmacy.⁸² IU Health also assures its patients that their “medical information and video connection are secured with end-to-end 128-bit encryption per the National Institute of Standards and Technology’s security requirements for cryptographic modules.”⁸³

C. Telemedicine as a Positive Development in Health Care Technology

While there are still improvements that need to be made in order for telemedicine’s effect to be as far reaching as possible, some of the benefits telemedicine can provide to the U.S. are already visible.⁸⁴

1. Cost

a. Cost to consumer

One major advantage for patients in using telehealth services is the cost.

78. *HIPAA Guidelines on Telemedicine*, HIPAA J., <https://www.hipaajournal.com/hipaa-guidelines-on-telemedicine/> [https://perma.cc/8XER-BY95].

79. *Id.* ePHI includes patient names, Social Security numbers, photographs, and payment information. Margaret Rouse, *Electronic Protected Health Information (ePHI)*, TECHTARGET, <http://searchhealthit.techtarget.com/definition/electronic-protected-health-information-ePHI> [https://perma.cc/F5VY-RSXM].

80. *HIPAA Guidelines on Telemedicine*, *supra* note 78.

81. *Community Virtual Care Frequently Asked Questions*, *supra* note 63.

82. *Id.*

83. *IU Health Video Visits Frequently Asked Questions*, *supra* note 71.

84. Bill Frist, *Telemedicine: A Solution to Address the Problems of Cost, Access, and Quality* HEALTH AFF. (July 23, 2015), <http://www.healthaffairs.org/doi/10.1377/hblog20150723.049490/full> [https://perma.cc/99VE-2F46].

Insurance coverage will ultimately determine what out-of-pocket cost the patient will be responsible for, but visits typically cost a flat, low rate as little as \$40.⁸⁵ IU Health and Franciscan Health, for example, each charge \$49, less than the typical urgent care visit.⁸⁶ This is a major savings to the consumer considering the average urgent care visit is \$156.⁸⁷ Additionally, the patient saves the cost of transportation and travel time that it takes to visit a provider in person.

Telehealth services can allow patients to receive hospital services at home, further cutting costs. Franciscan Health's Telehealth program, akin to their on demand virtual visits,⁸⁸ is a web-based program that allows providers to monitor patients' care through the comfort of the patients' own home.⁸⁹ Patients are given take-home equipment that allows providers to remotely monitor vital signs and gather other information that is securely sent to each patient's care team.⁹⁰ This program specifically focuses on patients with chronic conditions, such as congestive heart failure, multiple emergency room visits and frequent hospitalizations, or complex medication regimens.⁹¹

In Baltimore, results from Johns Hopkins Hospital's application of the Hospital at Home program⁹² showed the total cost of at-home care was 32% less than traditional hospital care (\$5,081 vs. \$7,480), the mean length of stay for patients was shorter by one-third (3.2 days vs. 4.9 days), and the incidence of delirium (among other complications) was dramatically lower (9% vs 24%).⁹³ With a similar study of the Hospital at Home program at Presbyterian Health Care Service in Albuquerque, spending was 19% lower using this model than the typical inpatient care for similar conditions.⁹⁴

85. *Id.*

86. *IU Health Video Visits Frequently Asked Questions*, *supra* note 71; *Community Virtual Care Frequently Asked Questions*, *supra* note 63.

87. *Comparing Costs and Quality of Care at Retail Clinics with That of Other Medical Settings for 3 Common Illnesses*, *ANNALS INTERNAL MED.*, <http://annals.org/aim/fullarticle/744702/comparing-costs-quality-care-retail-clinics-other-medical-settings-3> [<https://perma.cc/NN9H-6MR4>].

88. While this Note uses telemedicine and telehealth synonymously, in this instance Franciscan Health differentiates the two terms. Franciscan's Telehealth Program provides at-home long-term monitoring via the internet while Franciscan's on demand virtual visits, referred to as Telemedicine here, provides urgent care-like visits via the internet. *Supra*, note 69.

89. *Telehealth*, *supra* note 9.

90. *Id.*

91. *Id.*

92. The Hospital at Home program provides hospital-level care to a patient in their own home as a substitute for acute hospital care. The program was developed at Johns Hopkins Schools of Medicine and Public Health. *About Hospital at Home*, HOSP. HOME, <http://www.hospitalathome.org/about-us/overview.php> [<https://perma.cc/B6J5-HETE>].

93. *Telehealth: Helping Hospitals Deliver Cost-Effective Care*, AM. HOSP. ASS'N (2016), <http://www.aha.org/content/16/16telehealthissuebrief.pdf> [<https://perma.cc/2XVJ-76QW>].

94. *Id.*

b. Cost to system

While hospital expenditures to start telemedicine services differ slightly depending on the exact process the organization decides to follow, the costs for startup are relatively low and can be tailored to meet the provider's goals.⁹⁵ All-inclusive telemedicine systems range between \$20,000 and \$28,000 and include "the telemedicine software, primary care medical devices, and the mobile cart/case".⁹⁶

However, policymakers have expressed concern regarding the potential overutilization of telehealth services as they become more accessible.⁹⁷ Legislators contend that easier access to health care services will increase utilization by consumers and therefore result in additional expenses for programs such as Medicaid and Medicare as more recipients will take advantage of the easy-to-access health care services.⁹⁸ However, studies suggest that these fears are unfounded.⁹⁹ In fact, studies propose that Medicare should actually see a decrease in health care costs as the use of telemedicine (as opposed to traditional services) increases.¹⁰⁰

For example, the general cost for a telehealth visit is substantially lower than that of a traditional in-person acute care visit. Telehealth visits typically range from \$40 to \$50 while an in-person visit can range from \$136 to \$176.¹⁰¹ In states that reimburse telehealth visits at the same rate as in-person visits, Medicare could save an estimated \$45 per visit.¹⁰² Similarly, Medicare can save on patients needing long-term care, if the patients enroll in a Hospital at Home program, due to the substantially less amount of time the patient needs care.¹⁰³ As previously mentioned, patients enrolled in a Hospital at Home program typically require a mean length of stay that is one-third shorter than that of patients in the hospital¹⁰⁴ and 3.5 days in Johns Hopkins Hospital at Home program, as compared to 5.4 for inpatient admissions.¹⁰⁵

95. *I Want to "Do Telemedicine": What Is Involved and How Much Does It Cost?*, AMD GLOBAL TELEMEDICINE, (July 9, 2015), <https://www.amdtelemedicine.com/blog/article/i-want-to-telemedicine-what-involved-and-how-much-does-it-cost> [<https://perma.cc/3PH3-MAN4>].

96. *Id.*

97. *Telehealth: Helping Hospitals Deliver Cost-Effective Care*, *supra* note 93.

98. *Id.*; see also Najilla Nassery et al., *Systematic Overuse of Healthcare Services: A Conceptual Model*, 13 APPLIED HEALTH ECONOMICS AND HEALTH POLICY 1 (2015).

99. *Telehealth: Helping Hospitals Deliver Cost-Effective Care*, *supra* note 93.

100. Dale H. Yamamoto, *Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services*, ALLIANCE FOR CONNECTED CARE (2014).

101. *Id.*

102. *Id.*

103. *About Hospital at Home*, *supra* note 92.

104. *Id.*

105. Vida Foubister, *Hospital at Home Program in New Mexico Improves Care Quality and Patient Satisfaction While Reducing Care*, COMMONWEALTH FUND. (Sep. 2011), <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2011/august-september-2011/case->

Another area that demonstrates the cost-cutting benefits of telemedicine is that of required follow-up visits. A majority of diagnoses made during an initial telehealth visit can be resolved in that same visit.¹⁰⁶ When telehealth is used for an initial visit (instead of the emergency department or the physician's office), only 6% of patients require a follow-up, whereas 13% of in-person doctor office visits and 20% of emergency department visits for similar conditions require follow-up visits.¹⁰⁷

2. Access

Telemedicine provides twenty-four-hour access to a health care provider from any location so long as it is permitted under state law.¹⁰⁸ Using telehealth to provide specialty services may be more feasible for rural health care facilities than staffing the facilities with their own specialist providers.¹⁰⁹ Several types of services administered through telehealth technology have been used effectively in rural communities for a wide variety of patient care; examples include: chronic care management interventions, emergency care, home monitoring, intensive care units, long-term care, online therapy, and remote counseling.¹¹⁰

Students in Southwestern Jefferson County Schools, located in Southern Indiana, used to make a twenty-five minute drive to see the nearest doctor. In January 2017, as part of the telehealth initiative by the Indiana Rural Health Association, the school installed two virtual clinics where students can now simply walk down the hallway and connect with a physician via video.¹¹¹

IU Health Transplant offers several clinics in which patients can have their post-surgery follow-up appointments with a doctor in Indianapolis via telemedicine. For Mick Bonner, who received a kidney transplant, telemedicine was a life-saver. Being from Michigan City, yet seeing doctors in Indianapolis, Bonner had to make a six hour round trip each time he had a check-up. IU Health's clinic in Gary allowed Bonner to visit with his doctors in Indianapolis via video chat.¹¹²

study [<https://perma.cc/CM7S-VM7Z>].

106. *Id.*

107. *Telehealth: Helping Hospitals Deliver Cost-Effective Care*, *supra* note 93.

108. Frist, *supra* note 84.

109. *See I Want to "Do Telemedicine": What Is Involved and How Much Does It Cost?*, *supra* note 95 (demonstrating the ability to add medical devices, such as a digital stethoscope, for conducting specialized telemedicine services); *see also* IND. UNIV. PUB. POLICY INST., *supra* note 43 (showing the shortage of health care providers in rural Indiana).

110. *Telehealth Use in Rural Healthcare*, RURAL HEALTH INFO. HUB, <https://www.ruralhealthinfo.org/topics/telehealth> [<https://perma.cc/N5KR-6NG3>].

111. Carson Gerber, *Telehealth Clinics Boost Rural Access Across Indiana*, INDIANA ECONOMIC DIGEST (May 27, 2017, 8:09 AM), <http://www.indianaeconomicdigest.net/main.asp?SectionID=31&SubSectionID=135&ArticleID=88202> [<https://perma.cc/4MFR-FKWJ>].

112. Kathleen Quilligan, *IU Health Opens Telemedicine Outreach Clinic in Gary*, (Sept. 2, 2011), NWI.com, <http://www.nwitimes.com/news/local/lake/gary/iu-health-opens-telemedicine->

Visiting again the concept of the Hospital at Home telehealth program, such as the one practiced by Franciscan Health, patients are provided a much more convenient means of health care, particularly for those who are facing chronic conditions.¹¹³ Providers and patients alike may be concerned with the effectiveness of treatment in the home setting. However, a study of the Hospital at Home program at Johns Hopkins Medicine found no difference in rates of subsequent use of medical services or readmissions, and patient and family member satisfaction was higher in the home setting than among those offered inpatient hospital care.¹¹⁴

Recent Federal legislative actions have attempted to further increase the access to health care through telemedicine. Four bills before the 115th Congress held protentional for having a positive impact on the future of telehealth. The Creating Opportunities Now for Necessary and Effective Care Technologies for Health Act (“CONNECT”) and the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act of 2016 (“CHRONIC”) aimed to widen the scope of Medicare reimbursement for telehealth services, including the treatment of chronic medical conditions via telehealth-delivered services.¹¹⁵ Additionally, House Resolution 766 focused on Medicare patients by looking to implement a telehealth program for those Medicare patients who live in public housing.¹¹⁶ Finally, the Furthering Access to Stroke Telemedicine Act (“FAST”) aimed to increase Medicare recipients’ access to telestroke resources.¹¹⁷ However, none of the bills were signed into law.¹¹⁸

III. BREACH OF THE STANDARD OF CARE AND THE REGULATION OF TELEMEDICINE PRESCRIBING PRACTICES

A. Standard of Care and Medical Malpractice in Online Prescribing

With the increase in telemedicine prescribing comes the need for providers and private regulators to be more vigilant than ever in assuring that their prescription practices are not in violation of federal or state laws. Law makers use

outreach-clinic-in-gary/article_6d9b14c2-9cb7-5669-b49e-1cb04e7325f6.html
[<https://perma.cc/6MCF-2YX4>].

113. *Telehealth, supra* note 9.

114. Sarah Klein, “Hospital at Home” Programs Improve Outcomes, Lower Costs but Face Resistance from Providers and Payers, COMMONWEALTH FUND. (Sept. 2011), <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2011/august-september-2011/in-focus> [<https://perma.cc/PUM2-DS2L>].

115. Lauren Cranford, *What the American Health Care Act Might Mean for Telemedicine*, CHIRON HEALTH (May 8, 2017), <https://chironhealth.com/blog/american-health-care-act-might-mean-telemedicine/> [<https://perma.cc/39VT-UMZP>].

116. *Id.*

117. *Id.*

118. S. Res. 1016, 115th Cong. (2017-2018); S. Res. 870, 115th Cong. (2017-2018); H.R. Res. 766, 115th Cong. (2017-2018); H.R. Res. 1148, 115th Cong. (2017-2018).

the “standard of care” to furnish providers with a guideline as to what is minimally expected of them throughout their care of patients. While the medical community does not provide a general definition for the standard of care, the term is firmly defined by law as “the caution that a reasonable person in similar circumstances would exercise in providing care to a patient.”¹¹⁹ The legal definition of standard of care and what is and is not allowed in prescribing to patients via the internet is clear; thus, it should typically be clear if a provider has broken the law through their actions whilst prescribing to patients.

A brief case law analysis clarifies the circumstances that have constituted violation of the legal standard of care by providers in the treatment of a patient and subsequent provision of a prescription. In particular, there are many examples to draw upon in which providers, typically physicians, have been sanctioned by a state medical board for the unethical and sometimes unlawful prescription of medications.

In one such case, *Ancier v. Department Health Medical Quality Assurance Commission*, a physician, Dr. Ancier, prescribed medications to patients via the internet.¹²⁰ He was affiliated with an internet-based company offering prescription medication to customers without existing prescriptions.¹²¹ In order to acquire a prescription, a patient visited the company’s website, completed a questionnaire, attested to having undergone a recent physical examination, and affirmed he or she would schedule future routine physicals while on the medication.¹²² A patient also agreed to “consult local physicians or pharmacists about any adverse reactions or complications.”¹²³ A provider then reviewed the application and decided whether or not to issue the prescription.¹²⁴ Doctors were paid for each application they reviewed, regardless of whether the prescription was granted.¹²⁵ Dr. Ancier reviewed approximately 200,000 requests and issued 180,000 prescriptions between 2001 and 2004, despite not physically examining or personally interviewing any of the persons receiving these prescriptions.¹²⁶ The Washington Medical Quality Assurance Commission found that two of Dr. Ancier’s patients were placed at unreasonable risk of harm through this process.¹²⁷ Thus, the Commission revoked his license to practice medicine.¹²⁸

Similarly, in *Portales v. Kentucky Board of Medical Licensure*, a formal complaint was issued in May 2001, by the Kentucky Board of Medical

119. Dirk C. Strauss & J. Meirion Thomas, *What Does the Medical Profession Mean By “Standard of Care?”*, 27 J. CLINICAL ONCOLOGY 192, 192 (2009).

120. *Ancier v. Dep’t of Health, Med. Quality Assurance Comm’n*, 166 P.3d 829 (Wash. Ct. App. 2007).

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.*

127. *Id.*

128. *Id.*

Licensure.¹²⁹ Dr. Portales was involved in prescribing medications over the internet without prior consultations with patients.¹³⁰ This was found to be in violation of the Kentucky Medical Practice Act.¹³¹ The Court of Appeals of Kentucky affirmed the Kentucky Board of Medical Licensure's decision to revoke Dr. Portales' medical license.¹³²

In *Thompson v. State Board of Registration for the Healing Arts*, defendant Dr. Thompson reviewed a request form for weight loss medication submitted by an undercover agent over the internet.¹³³ Dr. Thompson issued the prescription without ever examining the "patient" or confirming the information in the online form.¹³⁴ Consequently, the Administrative Hearing Committee found that Dr. Thompson prescribed a controlled substance without a sufficient medical examination in violation of Missouri Revised Statute § 334.100.2(4)(h).¹³⁵ On appeal, the Missouri Court of Appeals found that Dr. Thompson was not disciplined for the act of prescribing medication over the internet, contrary to what he claimed, but rather for prescribing medicine to the undercover agent without performing a sufficient examination.¹³⁶

In *Golob v. Arizona Medical Board*, the Arizona Court of Appeals found that a physician deviated from the requisite standard of care when she failed to conduct physical examinations of her patients and failed to establish a physician-patient relationship.¹³⁷ The court determined that she created a potential harm to persons to whom she prescribed medication without physically examining them to ensure they did not have more serious medical conditions.¹³⁸

Prescription medication, including controlled substances, are at times essential to the effective treatment of a patient and telemedicine prescribing allows providers to treat their patients even more efficiently. However, as demonstrated with the above cases, physicians are placed in a high state of risk of violating state laws when prescribing online as there are additional requirements imposed on them as compared to simply prescribing in-person. In particular, there are additional regulations concerning the prescription of controlled substances, including opioids, through telemedicine.

129. *Portales v. Ky. Bd. of Med. Licensure*, No. 2007-CA-001060-MR, 2008 Ky. App. Unpub. LEXIS 654 (Ct. App. Nov. 21, 2008).

130. *Id.*

131. KY. REV. STAT. § 311.530, *et seq.*

132. *Portales v. Ky. Bd. of Med. Licensure*, *supra* note 127.

133. *Thompson v. State Bd. of Registration for the Healing Arts*, 244 S.W.3d 180 (Mo. Ct. App. 2007).

134. *Id.*

135. *Id.*

136. *Id.*

137. *Golob v. Ariz. Med. Bd.*, 176 P.3d 703 (Ariz. Ct. App. 2008).

138. *Id.*

B. Controlled Substances and Opioids

The Controlled Substances Act (“CSA”) classifies controlled substances and divides them into five schedules.¹³⁹ The Code of Federal Regulations¹⁴⁰ publishes an updated list annually of the substances that are considered to be controlled and into what schedule they fall.¹⁴¹ Substances are placed into their respective schedules based on whether they have a currently accepted medical use in the U.S., their relative abuse potential, and likelihood of causing dependence when abused.¹⁴²

Schedule I controlled substances have no accepted medical use in the U.S., a lack of accepted safety for use under medical supervision, and a high potential for abuse.¹⁴³ Schedule I substances include heroin, LSD, marijuana, and Ecstasy.¹⁴⁴ Schedule II controlled substances have a high potential for abuse that may lead to severe psychological or physical dependence.¹⁴⁵ Common Schedule II substances include hydromorphone, methadone, oxycodone, amphetamine, and fentanyl.¹⁴⁶ Schedule III Controlled Substances have a potential for abuse less than schedule I or II substances and abuse may lead to moderate or low physical dependence or high psychological dependence.¹⁴⁷ This schedule includes substances such as ketamine, products containing not more than ninety milligrams of codeine per dosage unit, and anabolic steroids.¹⁴⁸ Schedule IV Controlled Substances have a low potential for abuse as compared to schedule III.¹⁴⁹ Schedule IV substances include clonazepam, diazepam (Valium), and alprazolam (Xanax).¹⁵⁰ Finally, Schedule V Controlled Substances have a low potential for abuse in comparison to Schedule IV substances and consist primarily of preparations containing limited quantities of certain narcotics.¹⁵¹ This includes substances such as cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams and ezogabine.¹⁵²

Opioids are a derived form of opium which is found in the Asian poppy plant or a synthetic substance.¹⁵³ Opioids typically have a significant effect on an

139. *Controlled Substance Schedules*, Drug Enforcement Administration, <https://www.deadiversion.usdoj.gov/schedules/> [<https://perma.cc/6QS5-U2DE>].

140. 21 C.F.R. §§ 1308.11 - 1308.15 (2018).

141. *Controlled Substance Schedules*, *supra* note 137.

142. *Id.*

143. *Id.*

144. *Id.*

145. *Id.*

146. *Id.*

147. *Id.*

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.*

152. *Id.*

153. *Id.*

individual's perception of pain and therefore are widely used in the medical setting to treat pain.¹⁵⁴ Many controlled substances are classified as an opioid and all opioids are classified as controlled substances.¹⁵⁵ Opioids can be found in all five schedules of the CSA's classification.¹⁵⁶ For example, the Schedule I drug heroin is probably the most well-known opioid.¹⁵⁷ Schedule II methadone, fentanyl, and oxycodone, Schedule III buprenorphine products, Schedule IV tramadol, and Schedule V preparations made with codeine are also popular opioids.¹⁵⁸

In order to legally obtain a controlled substance deemed a schedule II through V,¹⁵⁹ a patient must have special permission, which typically comes in the form of a written prescription.¹⁶⁰ However, despite the requirement that these substances are obtained legally through a medical prescription, the U.S. is facing a significant opioid misuse and abuse problem.¹⁶¹ Opioid use, whether prescribed by a provider or not, can have a significant effect on the brain and body if misused.¹⁶² Continued abuse of opioids can lead to physical dependence and withdrawal symptoms if the individual attempts to stop usage after mismanagement.¹⁶³

In Indiana, opioid prescription rates rose from 103 per 100 population in 2008 to a peak of 112 per 100 population in 2012.¹⁶⁴ Since 2012, rates have been dropping with a rate of 84 prescriptions per 100 population in 2016.¹⁶⁵ However, opioid-related death rates have risen from 4.5 per 100,000 population in 2008, to 11.7 per 100,000 in 2016.¹⁶⁶ Drug deaths related to heroin and synthetic opioids have increased sharply, beginning in 2011 and 2015, respectively.¹⁶⁷

154. *Id.*

155. *Which Opiates are Listed as Controlled Substances?*, AM. ADDICTION CENTERS, <https://americanaddictioncenters.org/opiates/controlled-substances/> [https://perma.cc/XM8B-HMZA].

156. *Id.*

157. *Id.*

158. *Id.*

159. Substances classified as Schedule I cannot legally be obtained except with the permission of the U.S. Government because they have been found to provide no medical purposes. *Which Opiates are Listed as Controlled Substances?*, *supra* note 153.

160. *Id.*

161. *It All Starts with Knowledge and Understanding the Facts*, NEXTLEVEL RECOVERY IND., <http://www.in.gov/recovery/know-the-o/> [https://perma.cc/326G-U9PU].

162. *Id.*

163. *Id.*

164. *Data: Indiana by the Numbers*, NEXTLEVEL RECOVERY IND., <http://www.in.gov/recovery/1054.htm> [https://perma.cc/NP5L-M4PY].

165. *Id.*

166. *Id.*

167. *Id.*

C. Governing Authorities

In true health care fashion, telemedicine is subject to a wide array of laws, regulations, rules, and policies by the federal and state governments as well as the private sector. Just like traditional health care services, telemedicine faces regulations regarding cross-state licensure, informed consent, antitrust, fraud and abuse, and much more.¹⁶⁸ However, there is a disconnect between state laws and the policies of individual organizations. Additionally, states differ on what restrictions are placed on the prescribing practices of telemedicine providers, particularly in terms of controlled substances prescription. An analysis of recent changes to the Indiana Code will demonstrate how Indiana is supplying providers with the toolkit (i.e. a selection of medications they can prescribe) to effectively treat patients via telemedicine while still avoiding the risks associated with providing prescriptions for opioids without in-person consultation.

1. Federal Regulations

Just as with in-person medical treatment, telemedicine, particularly the prescribing practices thereof, raises a number of legal concerns. The Ryan Haight Online Pharmacy Consumer Protection Act (“RHOPCPA”) was created to address online pharmacies that sold controlled substances online.¹⁶⁹ The Act imposes federal penalties for providers who prescribe controlled substances via the internet using only a form as the method of diagnosis.¹⁷⁰ While providers who wish to prescribe controlled substances via telemedicine services need to be in compliance with the regulations set in place by the Act, it does not prohibit the prescription of controlled substances via telemedicine as a whole.¹⁷¹

As mentioned previously, the CSA places substances that are regulated in some manner by federal law into one of five schedules based on the substance’s medical use, potential for abuse, and safety or dependence liability.¹⁷² 21 U.S.C. § 829 specifically discusses dispensing controlled substances via the internet.¹⁷³ Controlled substances may only be delivered, distributed, or dispensed via the internet with a valid prescription.¹⁷⁴ A practitioner who provides such a prescription must have either conducted at least one in-person medical evaluation

168. *Telehealth Legal and Regulatory Module*, TELEHEALTH RESOURCE CENTER, <https://www.telehealthresourcecenter.org/legal-regulatory> [<https://perma.cc/H2L6-C7B5>].

169. Ryan Haight Online Pharmacy Consumer Protection Act of 2008, 110 Pub. L. No. 425, 122 Stat. 4820.

170. Nathaniel M. Lacktman, *Telemedicine Prescribing and Controlled Substances Laws*, HEALTH CARE LAW TODAY (Apr. 3, 2017), <https://www.healthcarelawtoday.com/2017/04/03/telemedicine-prescribing-and-controlled-substances-laws/> [<https://perma.cc/B8UC-JVEY>].

171. *Id.*

172. *The Controlled Substances Act*, DRUG ENFORCEMENT AGENCY, <https://www.dea.gov/controlled-substances-act> [<https://perma.cc/2H8T-ZDSL>].

173. Controlled Substances Act, 12 C.F.R. § 829 (2018).

174. *Id.*

of the patient or conducted an evaluation of the patient through the practice of telemedicine within the previous twenty-four months.¹⁷⁵ A provider who is practicing telemedicine is still required to follow the regulation that controlled substance prescriptions must be for a legitimate medical purpose and the prescriber must be acting within the usual course of professional practice.¹⁷⁶

On May 4, 2017, the U.S. House of Representatives passed the American Health Care Act of 2017.¹⁷⁷ Although it did not become law, it is still applicable to point out in an analysis of federal law that the Bill did not specifically incorporate the words “telehealth” or “telemedicine,”¹⁷⁸ suggesting that the federal government wishes to leave specific telemedicine regulations up to the states.

2. State Regulations

Although there are similarities in some of the statutory language used, no state statutes are exactly alike in how they regulate telemedicine.¹⁷⁹ Prior to 2016, Indiana’s Telehealth Services Pilot Program was the governing state rule on such activity.¹⁸⁰ A valid prescription was defined as one provided by a licensed physician for a legitimate medical purpose.¹⁸¹ Additionally, the prescribing physician must be acting in the usual course of professional practice and have first obtained a medical history and conducted an evaluation of the patient adequate to establish a diagnosis.¹⁸² The pilot program prescription requirement provided that “prescriptions [could] not be issued for a controlled substance or an abortifacient.”¹⁸³

D. Changes in Indiana Telemedicine Prescribing Laws in 2016 and 2017

As of 2018, Indiana has undergone two amendments to the Indiana Code sections governing the practice of Indiana telemedicine.¹⁸⁴

175. *Id.*

176. 74 C.F.R. § 1300 (2009).

177. *H.R. 1628 - American Health Care Act of 2017*, CONGRESS.GOV, <https://www.congress.gov/bill/115th-congress/house-bill/1628/text> [<https://perma.cc/XTZ9-RGYW>].

178. *Id.*

179. *State Telehealth Laws and Reimbursement Policies Report*, CENTERS FOR CONNECTED HEALTH POL’Y, <http://www.cchpca.org/state-telehealth-laws-and-reimbursement-policies-report> [<https://perma.cc/KNP3-98M3>].

180. IND. CODE 5-8 (2015).

181. IND. CODE 5-8-2(g) (2015).

182. IND. CODE 5-8-2(g) (2015).

183. IND. CODE 5-8-3(4) (2015).

184. IND. CODE 25-1-9.5-8 (2017).

1. *House Enrolled Act 1263: 2016*

In 2016, Indiana Governor Mike Pence signed into law Indiana House Enrolled Act No. 1263 (“HEA 1263”).¹⁸⁵ HEA 1263 replaced the previously mentioned Indiana Telehealth Pilot Program. Part of this amendment allows Indiana providers, assuming they have established a provider-patient relationship, to issue a prescription to a patient who is receiving telemedicine services.¹⁸⁶ In order to establish a provider-patient relationship via telemedicine, the provider must, at a minimum, obtain the patient’s name, contact information, and location.¹⁸⁷ Additionally, the provider must disclose his or her name and his or her role as a provider (i.e., physician, physician assistant, advanced practice nurse, or optometrist).¹⁸⁸ The provider is also required to (1) obtain informed consent from the patient; (2) gather the patient’s medical history and other information deemed necessary to make a diagnosis; (3) discuss with the patient the diagnosis and risks and benefits of different treatment options; (4) create and maintain a medical record for the patient; (5) issue proper follow-up care instruction; and (6) provide a telemedicine visit summary to the patient.¹⁸⁹ Most important to the substance of this Note, the Act allows providers to issue certain prescriptions without ever having to see the patient in person. This includes all prescriptions so long as they are not for a controlled substance, an abortion inducing drug, or an ophthalmic device.¹⁹⁰ While HEA 1263 made great strides in telemedicine practices in Indiana, the legislature further amended the Indiana Code a year later to allow providers even further autonomy in their medical treatment decisions.

2. *House Enrolled Act 1337: 2017*

Effective July 1, 2017, was yet another amendment to the Indiana Code concerning telehealth via House Enrolled Act 1337 (“HEA 1337”).¹⁹¹ In particular, this amendment further altered the prescription regulations on telemedicine services. The amendment removed the regulation that barred the prescription of controlled substances.¹⁹² Instead, the law now allows providers to prescribe non-opioid controlled substances via telemedicine without an initial in-person examination by the prescriber.¹⁹³ However, the patient is still required to be examined in-person by an Indiana provider to establish a treatment plan to

185. *Actions for House Bill 1263*, IN.GOV, <http://iga.in.gov/legislative/2016/bills/house/1263#document-46a1685d> (last reviewed Mar. 15, 2019).

186. H.B. 1263, 119th Gen. Assemb., Reg. Sess. (Ind. 2016).

187. *Id.*

188. *Id.*

189. *Id.*

190. IND. CODE 25-1-9.5-8 (2017). H.B. 1263, 119th Gen. Assemb., Reg. Sess. (Ind. 2016).

191. H.B. 1337, 120th Gen. Assemb., Reg. Sess. (Ind. 2017).

192. *Id.*

193. *Id.* However, the amendment does allow for an opioid prescription if the opioid is a partial agonist being used to treat or manage opioid dependence.

assist the prescriber with the patient's diagnosis.

In short, the Indiana Code has already been amended twice to reduce the restrictions on physicians offering telemedicine, particularly regarding their online prescribing abilities. This provides Indiana physicians with the ability to access a wide array of treatment options for their telemedicine patients.

E. Indiana in Comparison

In comparison to other state's statutes, Indiana's amendments land it in the middle ground of allowable prescription practices via telemedicine, particularly, prescriptions of controlled substances.¹⁹⁴ Most states at least have some form of policy or statement on internet prescribing.¹⁹⁵ Like Indiana, most states do not allow remote prescribing of abortion inducing drugs.¹⁹⁶

Also similar to Indiana, Alaska allows the prescribing of controlled substances via telemedicine when certain requirements are met, such as the provider maintaining a clear record that includes the patient's history, diagnosis, monitoring, and drugs prescribed.¹⁹⁷

Ohio telemedicine legislation also allows for the prescription of controlled substances via telemedicine, but in a very restrictive manner. For a prescription to be provided legally, both the provider and the patient must meet a series of requirements.¹⁹⁸ These requirements include that

- (1) The patient is an "active patient" of a colleague of the physician, and the prescription is being provided through an on-call or cross-coverage arrangement. An "active patient" is defined as a patient who has been seen at least once in the past 24 months by the physician, either in person or through a telemedicine visit;
- (2) the patient is at a Drug Enforcement Agency-registered hospital or clinic;
- (3) the patient is being treated by, and in the physical presence of, an Ohio-licensed physician or health care practitioner registered with the DEA;
- (4) the telemedicine consult is conducted by a practitioner who has obtained a DEA special registration for telemedicine;
- (5) a hospice program physician prescribes the controlled substance to a

194. Latoya Thomas & Gary Capistrant, *State Telemedicine Gaps Analysis*, AM. TELEMEDICINE ASS'N (2017), <http://utn.org/resources/downloads/50-state-telemedicine-gaps-analysis-physician-practice-standards-licensure.pdf> [<https://perma.cc/7WBR-UHT9>].

195. *Id.*

196. *Id.*

197. FEDERATION OF STATE MEDICAL BOARDS, INTERNET PRESCRIBING LANGUAGE: STATE-BY-STATE OVERVIEW 1 (2012), <https://web.archive.org/web/20150528220742/http://www.fsmb.org/Media/Default/PDF/Advocacy/InternetPrescribinglaw.pdf> [<https://perma.cc/8VEH-FCW2>].

198. OHIO ADMIN. CODE 4731-11-09 (2017).

hospice program patient in accordance with the board of pharmacy rules;
or;
(6) the physician is the medical director of, or attending physician at, an
“institutional facility,” the patient has been admitted as an inpatient to or
is a resident of an institutional facility, and the prescription is transmitted
to the pharmacy by a means that is compliant with Ohio board of
pharmacy rules.¹⁹⁹

F. Non-Legally Binding Policies

1. Telemedicine Providing Organizations

The individual organization providing telemedicine is the primary source of governance for a provider’s online prescription practices. For example, providers for Teladoc, a company that provides the platform to speak with a licensed provider via web, phone, or mobile app,²⁰⁰ offer prescriptions via a telemedicine visit for a wide range of medical conditions.²⁰¹ However, Teladoc notes that its providers are limited by the regulations of the state in which they are practicing and the state in which the patient resides.²⁰² Teladoc chooses not to allow the prescription of controlled substances, non-therapeutic medications, or other drugs that may be harmful to patients due to the proclivity for their abuse.²⁰³ Similarly, IU Health and CHN do not allow their providers to prescribe controlled substances via their telemedicine services.²⁰⁴

2. American Medical Association

Much like the American Bar Association’s Model Rules of Professional Conduct²⁰⁵ lays out ethical considerations for attorneys in their practice of law, the AMA Code of Medical Ethics provides standards of conduct for physicians in their practice of medicine.²⁰⁶ The AMA’s Council on Ethics and Judicial Affairs developed new ethical guidance on telehealth and telemedicine. In June

199. *Id.*

200. TELADOC, <https://www.teladoc.com> [<https://perma.cc/UK5B-MLCT>].

201. *Teladoc’s Prescription Policy*, TELADOC, <https://www.teladoc.com/providers/prescription-policy/> [<https://perma.cc/TSZ7-9KYU>].

202. *Id.*

203. *Id.*

204. *IU Health Video Visits Frequently Asked Questions*, *supra* note 71; *see Drug Schedules I-5*, IND. STATE DEP’T HEALTH, <https://www.in.gov/isdh/27380.htm> [<https://perma.cc/SG56-442V>] (listing controlled substances in Indiana).

205. *Model Rules of Professional Conduct*, A.B.A., https://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/model_rules_of_professional_conduct_table_of_contents.html [<https://perma.cc/29RX-HM6V>].

206. *AMA Code of Medical Ethics*, AMA, <https://www.ama-assn.org/delivering-care/ama-code-medical-ethics> [<https://perma.cc/XF67-M494>].

2016, the guidelines were adopted at the AMA's annual meeting.²⁰⁷ The AMA stated that no matter the model of care a provider is using, the patient should be able to trust that his or her provider will place the patient's welfare above other interests.²⁰⁸ Additionally, it is critical that providers deliver competent care, provide patients with the information necessary to make informed decisions about their care, and respect patients' privacy and confidentiality requirements.²⁰⁹

Per Policy H-480.948, Coverage of and Payment for Telemedicine, the AMA makes its own statement regarding what is required by a provider to create a patient-physician relationship in order to provide telemedicine services:

The AMA believes that a valid patient-physician relationship must be established before the provision of telemedicine services, through: (i) A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or (ii) A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or (iii) Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology. Exceptions include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.²¹⁰

There is a major disconnect between what Indiana state laws allow providers to do in terms of prescribing medications via telemedicine and what Indiana telemedicine organizations allow of their providers. While State law now allows providers to prescribe non-opioid controlled substances via telemedicine, so long as they meet the necessary requirements, telemedicine organizations such as Teladoc, IU Health, and CHN do not allow their providers to prescribe controlled substances. This places an unnecessary restriction on these particular providers and limits their "toolkit" in treating their patients.

207. *AMA Adopts New Guidance for Ethical Practice in Telemedicine*, AMA, (June 13, 2016), <https://www.ama-assn.org/ama-adopts-new-guidance-ethical-practice-telemedicine> [<https://perma.cc/C2C5-DQSD>].

208. *Id.*

209. *Id.*

210. AM. MED. ASS'N, 50-STATE SURVEY: ESTABLISHMENT OF A PATIENT-PHYSICIAN RELATIONSHIP VIA TELEMEDICINE (2017), <https://www.ama-assn.org/sites/default/files/media-browser/specialty%20group/arc/ama-chart-telemedicine-patient-physician-relationship.pdf> [<https://perma.cc/CP9T-WH8M>].

IV. CONCLUSION

Hospitals offering telemedicine services will increase access to care for their served community and will decrease their expenditure on health care services (primarily for urgent/primary care). It is important that states focus their telemedicine prescribing laws so as to allow providers with enough leeway to efficiently treat their patients while also avoiding harm to the patient or promoting opioid overuse. Indiana's updated telemedicine prescribing laws are a respectable middle ground and should be mirrored in other states' laws. In light of the recent opioid epidemic, physicians need to be vigilant about their prescription of opioids. However, many non-opioid controlled substances are an effective tool in treating illness and these substances should be available to telemedicine providers.

The updates to the Indiana Code may result in the Board of Medicine needing to rewrite some of its current telemedicine regulations to avoid conflict with the controlling provisions of the statute.²¹¹ The Hoosier state is doing well to serve as a role model for other states in the restructuring of their laws to provide greater access for patients at a lower cost and to give providers the toolkit they need to remotely provide services.

211. Nathaniel M. Lacktman, *Key Takeaways from Indiana's New Telemedicine Law*, HEALTH CARE LAW TODAY (Mar. 28, 2016) <https://www.healthcarelawtoday.com/2016/03/28/key-takeaways-from-indianas-new-telemedicine-law/> [<https://perma.cc/5TLP-XPU3>].