TELEMEDICINE AND TAX ISSUES: UBIT, INTERNATIONAL TAXATION, STATE AND LOCAL TAX ISSUES

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Nonprofit hospitals and health care providers are expanding their telemedicine capabilities and providing an increasing amount of service through the use of technology. When telemedicine services generate revenue, a tax-exempt hospital or health care provider will need to determine whether the revenue is subject to the unrelated business income tax (UBIT) at the federal and state level. The UBIT framework long applied by the IRS to hospitals and health care providers treats the delivery of health care services to the provider’s patients as furthering the provider’s exempt purpose. Delivery of services that are not necessarily health care but that are for the convenience of patients are also treated as a related activity under the statute. However, delivery of health care services or convenience services to individuals who are not patients of the provider are considered unrelated activities. Also, provision of ancillary services to another provider is also considered an unrelated trade or business unless the services are provided exclusively to a parent entity or to entities with which the provider is structurally and financially integrated.

If the telemedicine services generate revenue subject to UBIT at the federal level, the revenue is also taxable at the state level under state UBIT laws. If the telemedicine services are provided across state lines, the income may need to be apportioned between or amongst different states. If the telemedicine services are provided to patients or providers outside the United States, the provider will have to investigate potential tax liability in the foreign jurisdiction and the corresponding impact on any U.S. income tax it may owe. If the telemedicine services are an unrelated trade or business, purchases of supplies and equipment used for telemedicine may be subject to state sales and use tax. A state level provider tax may apply as well.

This outline reviews common telemedicine service models. It then discusses the UBIT framework the IRS currently applies for health care and analyzes how the various telemedicine models would be treated for UBIT purposes. Finally, the outline discusses apportionment of income among states, international taxation of telemedicine income earned by U.S. hospitals and health care providers, and sales and use tax.

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I. Telemedicine Services that Tax-Exempt Hospitals and Health Systems are Currently Providing

Hospitals and health care providers are offering health care services using telecommunications technology in a variety of structures and settings.

A. Provider monitors remote patient.

1. Provider communicates and provides services directly to patients at home or in non-traditional clinical settings using Internet-based platforms (real-time interactive).

Example

Virtual Cardiac Follow-Up after Hospital Discharge: This health care system recently implemented a virtual model of its Heart Success Transition Clinic at one of its regional facilities 55 miles away from the main hospital. Heart failure patients discharged from the regional hospital meet with the Heart Success Team via telemedicine, using basic videoconferencing and peripheral stethoscopes administered by home health nurses. The program has resulted in decreased readmission rates and increased self-management by patients. “During the 6 month pilot June through December 2013, 60 new patients have been enrolled in the virtual clinic and 165 virtual encounters. The 30-day all cause readmission rate at [the regional hospital] has decreased from 19.39% in 2010 to 9.82% in 2013.”

2. Provider remotely monitors patients with chronic or continuing care conditions while at home or in another facility (remote monitoring).

Example

Enhanced Critical Care/Mayo Clinic Health System (Rochester, MN): Through a program that started in 2013, the Mayo Clinic Health System is using telemedicine to monitor critically ill patients at six of its hospitals. ICU patients receive care from a local team, but are also monitored remotely 24/7 by specially trained physicians and nurses at an operations center in Rochester, Minnesota. Monitoring devices and information systems relay vital signs, test results, and images from the patient site to the operations center, where the remote care team reviews the data for small changes that might affect the patient’s health. High-definition TVs and cameras in the patient’s room also allow prompt access whenever the remote care team needs to communicate with local staff, patients, and families.

B. Provider reviews films, test results, and images for remote patient but no real-time contact with patient (store and forward).

Examples

Pediatric Teledermatology: In 2011, this academic medical center began a telemedicine program to address the shortage of pediatric dermatologists in the region. The local team takes high-quality photos of the pediatric patient’s affected skin and uploads the photos to the patient’s electronic medical record with a note explaining the chief complaint, medical history, and
physical examination. The record is then securely transmitted to a pediatric dermatologist at a
distant site, who reviews the materials and consults with the local dermatology resident regarding
treatment recommendations. This method of telemedicine is commonly referred to as “store and
forward” because of the asynchronous nature of the consultation.

Teleradiology: For decades, many hospitals have used store-and-forward technologies to support
teleradiology and pathology services. As an example, one academic medical center’s (AMC’s)
Teleradiology Service provides participating facilities with 24-hour, general coverage access to
its highly skilled radiologists who analyze and deliver final reports via a direct interface with the
facility’s information system or via fax. The program also offers consultations, second opinions,
and access to subspecialists in mammography and pediatric imaging.

C. Provider collaborates and communicates with specialists
not previously accessible (provider to provider consult)

Examples

Pediatric Teleneurosurgery (with patient contact): This hospital in a small city has implemented
a pediatric teleneurosurgery consultation project that allows some pediatric patients with head
injuries to stay in the state instead of being transported hundreds of miles away to a specialty
center. The American Academy of Pediatrics requires that all head injuries to children be
evaluated by a pediatric neurosurgeon. Through the program, local staff perform a CT scan of
the pediatric patient, and a neurosurgeon located at a distant hospital reviews the scan and
conducts a video assessment of the patient. The pediatric neurosurgeon provides oversight for
the patient in conjunction with the local trauma surgeon, and determines whether the patient is at
low risk for emergent complications and able to stay in the patient’s home community.

Telestroke Network Partner Program (with patient contact): The Telestroke Network Partner
Program connects community hospital emergency departments to stroke neurology experts at an
AMC Stroke Center for around-the-clock coverage. An emergency physician faced with a
possible acute stroke patient at a participating hospital may contact the AMC’s telestroke consult
hotline, and within 15 minutes, a specialist will interview the patient and perform the stroke-
specific neurologic exam via two-way video conferencing. The platform also allows the AMC
stroke specialist to view local CT scans and other diagnostic images.

Tumor consult: Mayo Clinic now offers, as part of the services available through its Mayo
Clinic Care Network, eTumor Board Conferences. These are weekly conferences that promote
informal multidisciplinary discussions of cancer treatment options. Although specific cases may
be discussed, the conferences are designed as an educational opportunity as much as to design
treatment and care of a specific case. Cases are selected among those submitted, and no specific
case is guaranteed a discussion. In addition, physicians can participate in the discussion even if
they do not have a particular case being discussed.

II. Existing IRS Framework for Applying UBIT to Health Care Providers

A hospital or other health care provider is considered to be furthering its exempt purposes when it provides health care services to its patients. The revenue it generates from patient care is, therefore, not subject to federal income tax. Under section 513(a)(2), a hospital or health care provider is also not subject to tax on revenue from services it provides for the convenience of its patients, such as pharmacy services, cafeterias, or other services that facilitate family visits and comfort for inpatients. However, the IRS takes the position that unrelated business income tax does apply to revenue a tax-exempt hospital or health care provider generates from serving individuals who are not its patients if the services are regularly carried on for the purpose of making a profit. Unless one of a limited set of exceptions apply, providing goods or services, including clinical services, laboratory services and pharmacy sales, to individuals who are not the tax-exempt organization’s patients or to other health care providers is generally considered by the IRS to be an unrelated trade or business.

A. Services for the Provider’s Patient

The IRS has developed its view of who is a patient under IRC § 513(a)(2), which provides that a trade or business carried on by a section 501(c)(3) organization “primarily for the convenience of its . . . patients” is not considered an unrelated trade or business.

1. The Service set forth its position on who is a patient of a hospital for purposes of § 513(a)(2) in Rev. Rul. 68-376, 1968-2 C.B. 246, in which it ruled on the UBIT treatment of sales by a hospital pharmacy. Under the ruling, all of the following are considered patients of the hospital: (a) an individual admitted as an in-patient, (b) an individual receiving general, emergency or diagnostic outpatient services, (c) a person directly referred to the hospital’s outpatient facilities by his private physician for specific diagnostic or treatment procedures, (d) a person refilling a prescription written during the course of his treatment as a patient of the hospital, (e) a person receiving medical services as part of a hospital administered home care program, and (f) a person receiving medical care and services in a hospital-affiliated extended care facility.

2. Sales not only of drugs and services but also of equipment to patients fall under the exemption provided by § 513(a)(2). For example, a hospital’s sales of hearing aids to its patients, who it otherwise served with rehabilitation services and evaluations, was not considered to generate UBIT. Rev. Rul. 78-435 1978-2 C.B. 181

3. For purposes of applying section 513(a)(2), the Service takes the position that private patients of members of the hospital’s medical staff are not considered patients of the hospital if the hospital is performing tests in its laboratory or selling them products from its pharmacy that are not in connection with treating the individual as an inpatient, outpatient or patient in a hospital-affiliated program or facility. Therefore, the revenue from sales to them is UBIT. See Rev. Rul. 85-109, 1985-2 C.B. 165. (At least one court has disagreed on the ultimate conclusion, holding that pharmacy sales to private patients of the medical staff are
substantially related to the provision of hospital services and therefore not subject to UBIT without needing to apply the exception in IRC 513(a)(2). See Hi-Plains Hospital v. United States, 670 F.2d 528 (5th Cir. 1982).

4. Where a hospital enters into a joint venture to operate a rehabilitation hospital and provides non-medical services to patients of the joint venture hospital, the revenue is (a) for the convenience of patients to the extent patients of the rehabilitation hospital are also patients of the hospital, and (b) considered related to the hospital’s exempt purpose in the same proportion to total revenue received for the non-medical services as the hospital’s proportion of ownership in the joint venture because it is the equivalent of the hospital providing services to itself. PLR 9323030 (March 16, 1993) (rehabilitation hospital as a joint venture).

A. Services for Another Provider

1. Consulting Services

Consulting services provided to other section 501(c)(3) organizations do not further exempt purposes if the services are provided at or above cost, particularly where a commercial counterpart makes the comparable services available. B.S.W. Group v. Commissioner, 70 T.C. 352 (1978). The IRS applies this same principle to ancillary services, such as management services, financial services and IT services, provided to an unrelated entity. The IRS infers that ancillary services are unrelated from B.S.W. Group and section 513(e), which provides a limited UBIT exemption for the provision of certain enumerated ancillary services at or below cost to hospitals with 100 or fewer beds. Non-medical services for other hospitals that fall outside the statutory UBIT exemption of section 513(e) are assumed to be unrelated. See R. Darling and M. Friedlander, Virtual Mergers: Hospital Joint Operating Agreement Affiliations, Exempt Organizations Continuing Professional Education Text, 1997.

2. Affiliated Providers

If two hospitals are in a parent-subsidiary relationship, and the subsidiary earns a profit from providing services to the parent that the parent would otherwise provide for itself, the generation of profit will not violate the requirements for exemption nor generate UBIT. Treas. Reg. § 1.502-1(b); Geisinger Health Plan v. Commissioner, 30 F. 3d 494 (3d Cir. 1994). Based on the same reasoning, the Service has ruled that hospitals further exempt purposes when they provide services to other hospitals with which they have an affiliation or joint operating agreement that does not create a parent-subsidiary relationship between the hospitals but provides for coordinated governance and operation through a common parent. E.g., PLR 9844032 (October 10, 1998). PLR 200215058 (April 12, 2002); PLR: 9251041 (September 25, 1992); PLR 8737101. See also, R. Darling and M. Friedlander, Virtual Mergers: Hospital Joint Operating Agreement Affiliations, Exempt Organizations Continuing Professional Education Text, 1997.

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3 If a hospital provides certain enumerated services to other hospitals, all of which have no more than 100 in-patients, and the services would be related to furthering exempt purposes if the recipient hospitals performed the services themselves; and the services are performed at or below cost, then the provision of the services is not considered an unrelated trade or business. IRC § 513(e). The services covered by this exception include clinical services, laboratory services, warehousing and communications among other things. IRC § 501(e)(1)(A).
B. Casual Sales

Services provided to individuals who are not otherwise patients of a hospital or health care provider are considered related to exempt purposes in certain limited situations. Sales made infrequently to patients of members of the medical staff who are seen for appointments at the hospital and are not otherwise the hospital’s patients are not considered UBIT if the sales are infrequent, represent a small fraction of the total pharmacy sales, and if the hospital pharmacy does not otherwise sell to the general public. Rev. Rul. 68-374 1968-2 C.B. 242.

C. Goods and Services Provided Where the Community Otherwise Lacks Access

In Rev. Rul. 85-110, 1985-2 C.B. 166, the Service held that hospital revenue from performing laboratory testing for non-patients was UBIT where comparable services were otherwise available from commercial laboratories in the same metropolitan community. However, the ruling also stated that “if other laboratories are not available within a reasonable distance from the area served by the hospital or are clearly inadequate or unable to conduct tests needed by hospital non-patients, a hospital’s testing services may further its exempt function of promoting community health.” The Service applied this principle when it ruled that a hospital was furthering charitable purposes through provision of computerized electrocardiogram services with faster delivery and prompt expert readings to other hospitals, nursing facilities and private practices in its community that were the only reasonably available services of that kind in the community. PLR 8736046 (June 10, 1987). See also PLR 8721103 (laboratory services when closest alternative is far away); PLR 8941082 (lab tests in rural area); PLR 9352030 (radiology joint venture expanding access).

D. Services that Contribute to Medical Education

Performance of hospital laboratory services for patients of doctors on the medical staff who are not otherwise patients of the hospital can still further an exempt purpose if the hospital needs the specimens for use in its teaching program. Id. See St. Luke's Hospital of Kansas City v. United States, 494 F. Supp. 85 (W.D. Mo. 1980). See also Rev. Rul. 85-109, 1985-2 C.B. 165 (holding that IRS will follow the court’s decision with respect to laboratory services furthering education but will not consider services for private patients of the medical staff to fall within the convenience exception of section 513(a)(2)).

E. Health Need or Financial Need of Service Recipient

Providing low-cost bus transportation to the elderly and those with disabilities who do not otherwise have access to transportation that will allow them to get to medical facilities is a charitable activity. Rev. Rul. 77-246 1977-2 C.B. 190. This ruling suggests that if a health care provider supplied a health care service or an ancillary service exclusively to a charitable class of
individuals, the activity could be furthering an exempt purpose even if the service recipients were not patients of the health care provider.

F. Income Derived from Research

Income that a hospital derives from performing research for an unrelated party is excluded from unrelated business taxable income. IRC § 512(b)(8). Also, performance of scientific research in the public interest furthers a scientific purpose (which is an exempt purpose under section 501(c)(3)). Treas. Reg. § 1.501(c)(3)-1(d)(5). Scientific research can be in the public interest if results are made publicly available. See Treas. Reg. § 1.501(c)(3)-1(d)(5)(iii). Rev. Rul. 76-296, 1976-2 CB 141.

III. UBIT Analysis of Telemedicine Activities

The Service has not yet published a position on the application of UBIT to revenue generated specifically from the conduct of telemedicine services. When a tax-exempt health care provider earns revenue from regularly carrying on telemedicine services, the IRS can be expected to analyze the UBIT treatment of the revenue under the UBIT framework that distinguishes services for patients from services for non-patients. As there are a number of commercial enterprises providing telemedicine services, and as the principal policy goal of UBIT is to protect against unfair competition with commercial counterparts, it is likely the Service will be concerned about the potential for UBIT, and presumably will apply the existing principles for applying UBIT to a health care provider’s services. For services offered by a provider via telemedicine channels to an individual who it treats as its patient for all purposes (e.g., informed consent, HIPAA, creation of a medical record, billing, licensure), UBIT should not apply under the existing framework. However, if the factors do not all uniformly point to the same answer, as may occur if the telemedicine provider bills the other provider rather than the patient, or if there is a second provider serving as intermediary between the provider of services and the patient, there may be uncertainty as to whether the telemedicine provider has a patient relationship with the individual benefiting from the services.

A. Patient Relationship

It can be difficult to determine whether telemedicine services are being supplied provider to provider or provider to patient.4 The existing tax guidance, Rev. Rul. 68-376, Rev. Rul. 85-109 and Rev. Rul. 85-110, distinguishes between services provided to patients of the hospital and services provided to private patients of physicians on the hospital’s medical staff. In each of the three rulings, the services in question are pharmacy or laboratory services, not physician

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4 Regardless of whether services are considered provider-to-provider or provider-to-patient, telemedicine arrangements often have the potential to implicate federal and state laws against fraud and abuse because they sometimes involve provision of equipment (sometimes without cost), and direct-to-consumer programs typically necessitate referral activities for follow-up care. See, e.g., U.S. Dep’t of Health & Human Servs., Office of Inspector Gen., Advisory Op. No. 04-07 (June 17, 2004) (cautioning that some telemedicine networks can generate prohibited remuneration under the anti-kickback statute, but recognizing sufficient safeguards reduced such risks in the present case). Because many states independently regulate referral activities, physician advertising, and incentive structures, state-level fraud and abuse considerations may further complicate the development of a multistate telemedicine program.
services. Where the pharmacy filled a prescription and performed a diagnostic test ordered by the physician for an individual who received no other services from the hospital in connection with the prescription or diagnostic test, the patient was considered not to be a patient of the hospital. Where a hospital is supplying physician services or services of another medical professional via telemedicine, rather than laboratory or pharmacy services, the questions are different. If the physician is connecting to the patient and no intermediary provider is involved, the key question would be whether the physician is providing services on behalf of the hospital or using the technology to provide services as part of a private practice. If the physicians are employees of the telemedicine provider hospital, or the telemedicine provider hospital is deploying the physicians’ services under a professional services agreement that commits the physicians to performing this line of service for the telemedicine provider hospital, then the services should be viewed as provided by the hospital and not by a distinct private practice. However, if the hospital has facilities that can be used for electronic patient interface that it makes available to members of its medical staff for use in treating their private practice patients, and it bills for the use of the facilities, it may be difficult to claim that the patients being served are also patients of the hospital.

The telemedicine models described in the first part of the outline can be useful in illustrating possible analysis. The Virtual Cardiac Follow-Up Services are provided to patients who have been discharged from the telemedicine provider’s hospital as part of a program run by the telemedicine provider’s health system. Under Rev. Rul. 68-376, a person “receiving medical services as part of a hospital-administered home care program” is considered a patient of the hospital for UBIT purposes, and revenue from services provided to the hospital’s patients is not subject to UBIT. In this model, the patient has been a traditional inpatient, and the telemedicine services are delivered as part of a program the hospital itself administers. Existing IRS guidance supports the view that this is a related service provided to individuals who are patients of the hospital.

Teleradiology services and telepathology services have been in existence for some time. As practitioners in both areas often serve their patients without having direct contact with them, the patient relationship may be consistent with the traditional model and not be affected very significantly by the fact that the practitioners may be geographically removed from the patients, reviewing digitally transported images rather than original test results. However, for the pediatric teledermatology program, the pediatric telenuroscopy program, and the telestroke network program, determining whether the patients are patients of the telemedicine provider hospital is less clear because of the involvement of both a telemedicine provider hospital and an intermediary provider hospital.

To the extent the telemedicine provider hospitals (where the physicians or other medical professionals are located who provide the telemedicine services) and the intermediary provider hospitals (which serve as the sites that receive the patients and establish the connection between the patients and the telemedicine providers) have a corporate relationship, joint operating agreement or joint affiliation agreement, the patient may be considered the patient of the telemedicine provider hospital for purposes of a UBIT determination based on the integral part/Geisinger analysis. However, if the intermediary provider hospitals have no affiliation with the telemedicine provider, UBIT analysis under the Service’s existing framework would look next to whether the patients receiving the services are patients of the telemedicine provider.
there is direct interaction between the telemedicine provider and the individual needing care, the following elements if present in the interaction between them may provide evidence of a physician-patient relationship:

- Collection of informed consent by the telemedicine provider to treat the patient.
- Creation of a medical record by the telemedicine provider and issuance of a HIPAA privacy notice to the patient.
- Collection of a medical history by the telemedicine provider from the patient.

Beyond the details of how the physician or other medical professional and the individual interact, there are other factors that are relevant in determining whether the telemedicine provider has established a patient relationship with the individual.

1. Licensure

Physician licensure is primarily a matter of state law, so providers must consider state-specific requirements when constructing telemedicine arrangements. Generally, licensure is required in the jurisdiction where the patient is located at the time of the telemedicine consultation. For example, a physician in Massachusetts who is videoconferencing with a patient located in a Vermont hospital usually must be licensed in Vermont to comply with state law. Some states have relaxed traditional barriers to the interstate practice of medicine. At least 10 states provide a conditional registration or special-purpose license allowing a physician licensed in another state to furnish telemedicine services to patients in the state of registration. See, e.g., Minn. Stat. 147.032 (setting forth certain conditions, for example, that telemedicine-registered physicians may not open an office in Minnesota or meet in person with patients in the state). Telemedicine arrangements must often comply with other state regulatory requirements including:

a. Physician-patient relationship requirements (some states require a prior, in-person physical examination to establish the relationship);

b. Standard of care obligations (such as whether the same standard of care applies to telemedicine consultations as applies to in-person visits);

c. Informed consent rules (such as whether the physician must inform the patient about potential risks and benefits of telemedicine and document the patient’s consent); and

d. Electronic prescribing restrictions (such as whether “appropriate” equipment for transmitting real-time vital signs is required and whether the physician must discuss treatment options with the patient).

On April 26, 2014, the Federation of State Medical Boards (“FSMB”) adopted the Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (the
While nonbinding, the policy statement serves as a valuable guide for state legislatures and medical boards, many of which are adopting or revising standards for the utilization of communications technologies in health care delivery. The Model Policy proposes a specific definition for “telemedicine”: “the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider.” This description is intended to apply to a direct-to-consumer form of telemedicine, and by its own terms, does not apply to physician-to-physician consultations. Thus, the Model Policy expects physicians providing telemedicine services to establish a physician-patient relationship through measures such as verifying the patient’s location and gathering necessary consents and is not directly helpful in determining whether a physician-patient relationship exists. With respect to licensure, the Model Policy states that a physician must be licensed “or under the jurisdiction” of the medical board of the states where the patient is located. This leaves states with discretion to adopt approaches like Minnesota’s conditional or special purpose registration. With respect to standards of care, the Model Policy endorses standards of care for telemedicine consistent with traditional in-person standards, providing that “treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings.” The Model Policy also requires providers to develop plans for continuity of care and to make referrals in emergency situations. See Attachment A, Federation of State Medical Boards, Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.

The Federation of State Medical Boards has also developed a model interstate medical licensure compact that provides a streamlined process allowing physicians to become licensed in multiple states. The compact continues to take the position that the physician needs to be licensed in the state where the patient is located, but adoption of the compact would make that licensure process substantially easier. See Attachment B, Federation of State Medical Boards, Interstate Medical Licensure Compact. Individual states may begin to consider legislation that would enable their states to participate in the compact.

If telemedicine services are being provided to patients in other states, the licensure or registration the physicians secure in the state(s) where the patients are located can help establish that the telemedicine patients are patients of the telemedicine provider hospital. However, if the telemedicine services are being provided to an intermediary hospital or provider in such a fashion that the telemedicine provider does not think its doctors must be licensed or registered in the state where the client provider is located (as may occur with some store-and-forward activities), then the absence of licensure or registration may work against a claim of a physician-patient relationship. The language in the FSMB Model Policy defining telemedicine services in the direct-to-consumer model as occurring “with or without an intervening health care provider” supports the view that the patient is a patient of the telemedicine provider even if the patient is also a patient of a client hospital or health care provider that hosts the telecommunications link.

2. Medical Staff and Credentialing

A telemedicine provider hospital may have greater difficulty claiming a patient relationship if an intermediary provider hospital admits the physicians providing the telemedicine services to its medical staff or takes responsibility for ensuring the provider is
credentialed for participation in Medicare and Medicaid. The intermediary hospital may take that action to protect against any questions or issues while the rules with respect to licensure and liability are still evolving. It may be a policy or practice they have adopted in response to having telemedicine services provided through entities that are not hospitals with their own medical staff credentialing processes. Ensuring that the physicians are credentialed to participate in Medicare and Medicaid may be necessary in order for the intermediary hospital to seek reimbursement for the services it is providing to the patient. However, putting the telemedicine providers on the intermediary hospital’s medical staff may cut against the telemedicine provider hospital’s claim that the physicians are creating a patient relationship with the telemedicine provider hospital.

3. Billing

Billing practices might also figure into whether a nonprofit hospital providing telemedicine services can claim that the patients receiving the services are patients of the hospital. If the patient and the patient’s insurer are billed by the telemedicine provider hospital for the service, that would strongly support the position that the patient is a patient of the telemedicine provider hospital. However, if the intermediary provider hospital bills the patient, and the telemedicine provider bills the intermediary provider hospital, it gives the appearance of a provider to provider consult (unless the telemedicine provider hospital has assigned its right to bill and collect to the intermediary hospital).

If the patient is insured through Medicare, it may be difficult to bill Medicare for the services even if it is abundantly clear that the patient is a patient of the telemedicine provider hospital. Medicare provides rather limited coverage of “telehealth” services, with eligibility for reimbursement based on several factors:

- Geography (the patient must be located in a “rural” area—i.e., either in a county outside of a Metropolitan Statistical Area or in a rural census tract located within a Metropolitan Statistical Area);
- Facility where the patient is located (qualifying facilities include hospitals, physician offices, and skilled nursing facilities, but do not include the patient’s home);
- Technology used (interactive, real-time audio and video equipment qualify, whereas asynchronous store-and-forward technologies generally do not);
- Practitioner providing the service (physicians and nurse practitioners qualify, whereas physical therapists do not); and
- Type of service (only certain services, such as office visits, outpatient visits, and psychotherapy, are covered as updated annually in the Physician Fee Schedule). See generally 42 C.F.R. § 410.78.

As part of the Physician Fee Schedule for 2015, the Centers for Medicare & Medicaid (CMS) has proposed coverage of chronic care management services provided in non-face-to-face contexts. The CMS description of chronic care management encompasses some services provided via telemedicine technologies, such as secure messaging, Internet, and other
asynchronous consultations between providers and beneficiaries. See Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015, 79 Fed. Reg. 40,318, 40,365 (proposed July 11, 2014) (describing chronic care management as “a unique [Physician Fee Schedule] service designed to pay separately for non-face-to-face care coordination services furnished to Medicare beneficiaries . . . with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline”). As for Medicaid, 45 states and the District of Columbia provide some form of reimbursement for telemedicine services, although the requirements and scope of coverage significantly differ by state.

Private coverage of telemedicine services also varies by payer and state. Many states require payers to provide benefits for telemedicine on the same terms as they provide coverage for in-person care. Twenty-one states and the District of Columbia have adopted such parity legislation, and several other states are considering similar legislation. See, e.g., Ariz. Rev. Stat. § 20-841.09 (requiring parity only for certain categories, such as trauma, cardiology, and dermatology, for services provided to subscribers in rural areas); Me. Rev. Stat. tit. 24-A, § 4316 (requiring parity for interactive telemedicine, but not for asynchronous technologies). Some commercial payers and managed care plans with an interest in reducing expenses for high-cost populations have developed programs to cover telemedicine services even when not required to do so by state law. For example, in 2013, Cigna launched a joint venture with telehealth provider MDLIVE to offer eligible health plan customers around-the-clock access to video consultations with primary care and specialist physicians. See Press Release, Cigna, The Doctor Will See You Now: Cigna Teams with MDLIVE to Offer Health Care Access 24/7/365 (May 10, 2013).

On June 11, 2014, the American Medical Association (“AMA”) approved its Council on Medical Services’ Report on the Coverage of and Payment for Telemedicine (the “Report”). Although also nonbinding, the Coverage Report sets forth guiding principles for the reimbursement of medical services furnished via telemedicine. It states as follows: “physicians should uniformly be compensated for their professional services at a fair fee for established patients with whom the physician has had previous face-to-face professional contact, whether the current consultation service is rendered by telephone, fax, electronic mail or other forms of communication. Likewise, [AMA Policy] states that CMS should reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various “fee splitting” or “fee sharing” payment schemes.” The Report also summarizes existing Medicare and Medicaid coverage policies and describes common use cases. Unlike the FSMB Model Policy, the AMA Report does not propose a single definition for “telemedicine” and instead addresses issues across three categories: store-and-forward telemedicine, remote-monitoring telemedicine, and real-time interactive telemedicine. The Report recommends that telemedicine services be covered and paid subject to several conditions, such as the establishment of a valid physician-patient relationship (noting that “face-to-face encounter could occur in person or virtually through real-time audio and video technology”), compliance with all state licensure laws (including that the physician be licensed or otherwise authorized in the state where the patient is located), and disclosure and informed consent requirements (including disclosing the

4. Jurisdiction for Malpractice Claims

Generally, medical malpractice actions require “the existence of a duty flowing from the physician-patient relationship”—a relationship that, as courts have held, does not necessarily involve direct physical contact. See, e.g., Lopez v. Aziz, 852 S.W.2d 303, 305-06 (Tex. App. 1993). The virtual nature of telemedicine presents unique challenges for the common law of torts, specifically with respect to determining where the injury occurred and what contacts the parties established with a particular state. To address these uncertainties, some states, such as Nevada, have enacted statutes deeming the location of a medical act as the place where the patient was located. See, e.g., Nev. Rev. Stat. § 630.049. Illinois expressly subjects out-of-state physicians to its jurisdiction if they practice medicine via telemedicine or provide consulting services for the benefit of Illinois patients. 225 Ill. Comp. Stat. § 60/49.5(e). If the applicable state law would hold the out-of-state nonprofit hospital telemedicine provider liable for malpractice resulting from the telemedicine services for a patient in the state, then the state law is implying that the physicians working on behalf of the nonprofit hospital has a patient relationship with the telemedicine patient. Similarly, if the nonprofit hospital’s malpractice carrier covers the telemedicine services, the carrier is acknowledging a patient relationship.

5. Corporate Practice of Medicine Considerations

The corporate practice of medicine doctrine can complicate the picture in trying to determine whether there is a physician-patient relationship. More than half of U.S. states prohibit non-physicians, including general business corporations, from directly employing physicians for fee-generating services and from otherwise interfering with their professional judgment. Specific rules regarding entity formation, financing, and board membership vary by state, and these rules often affect the structure of the transaction or affiliation. A provider operating in corporate form in state A may not be able to use its employed physicians to provide telemedicine services to patients in state B, which bars the corporate practice of medicine, unless it works through a physician-owned entity in state B. The insertion of the additional entity complicates the question of whether the physicians providing the telemedicine services have a physician-patient relationship with the patient or whether this a consulting arrangement. As noted above, the FSMB Model Policy indicates that the intermediation of another provider between the provider of telemedicine services and the patient should not affect the fundamental physician-patient relationship between the physician providing evaluation, diagnosis and instructions for care, and the patient benefiting from the care.

Example

In September 2014, Memorial Health System announced it was joining the Mayo Clinic Care Network. One of the services provided in this relationship is econsults. These are ordinarily in the form of store-and-forward, provider-to-provider consults. The Texas Medical Board has a

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5 http://www.methodisthealthsystem.org/body.cfm?id=93&action=detail&ref=1043
provision for an Out-of-State Telemedicine License \(^6\) the scope of which did not fit the Mayo process. Therefore, Mayo Clinic formed a Texas nonprofit corporation that has been approved as a Texas Nonprofit Health Organization. This organization will operate as a taxable nonprofit subsidiary of Mayo Clinic to provide those services which would be covered by the Texas Medical Board rules. A question to consider, could such an entity apply for exempt status? What would it take to get such status?

B. Filling a Shortage of Services

If it is not clear that the telemedicine provider hospital has a patient relationship with the patient benefiting from the telemedicine services, or if the telemedicine provider providing the services and the intermediary provider receiving them are operating with the understanding that the services are provider-to-provider consults, then the telemedicine provider will need to look to other possible bases for claiming that the revenue is not subject to UBIT. One possibility is that the services are filling a shortage. The pediatric teledermatology program, the pediatric teleneurosurgery program, and the telestroke network program all provide specialized medical services to providers who either have a shortage of the services generally or may not have access to the services at times when a patient is having an emergency. Rev. Rul. 85-110 states that a section 501(c)(3) hospital or other health care entity promotes the health of the community when it provides services in an area where they are not otherwise available within a reasonable distance or where “the absence of [the services] would hinder or jeopardize the medical care of patients or other health care institutions lacking” the services. The pediatric teledermatology program, the pediatric teleneurosurgery program, and the telestroke network program described above respond to a shortage or emergency need in a way that is comparable to the laboratory services, pharmacy services, imaging services, and radiology services all held in private letter rulings to further charitable purposes. Therefore, there is a sound basis for concluding that revenue generated by the services should not be subject to UBIT even if the patient receiving the services is not considered the patient of the telemedicine provider.

Providers of teleradiology and telepathology services may have less difficulty claiming a patient relationship with the recipient of the services. If they do, these services may or may not be filling a shortage, or they may be filling a shortage that occurs only at certain times of the day or week. The hospital receiving the services might use them to cover a shortage on some nights and weekends, to access specialists it does not have for some cases, and for convenience and cost savings the rest of the time. Under the fragmentation rule of Treas. Reg. § 1.513-1(b), for activities that are a mix of related and unrelated business activity, the intermediary provider hospital could apply the rationale of Rev. Rul. 85-110 to the related parts of the services and a different analysis to the unrelated part.

C. Service to Related or Affiliated Provider

Where one section 501(c)(3) entity provides services to another section 501(c)(3) entity with which it has a parent/subsidiary relationship, the Service takes the position that revenue generated from providing the services is not subject to UBIT, relying on the integral part regulations at Treas. Reg. § 1.502-1(b) and Geisinger Health Plan v. Commissioner, 30 F. 3d

\(^6\) http://www.tmb.state.tx.us/page/telemedicine-license
The Service has also issued rulings concluding that a joint operating or affiliation agreement can effectively bind entities as if they were parent and subsidiary, such that revenue generated from transactions between the entities is treated as related to their exempt purpose. See, e.g., PLR 9844032 (August 4, 1998).

The Enhanced Critical Care monitoring services described above are provided by one facility in the Mayo Clinic Health System to patients admitted to another facility of Mayo Clinic Health System. There is a common parent over the different hospitals and facilities. To the extent one of the hospitals is paying the central monitoring facility for its services, there is a sound basis for concluding that the revenue should not be subject to UBIT. Query whether the same rationale would apply if a telemedicine provider provider supplied telemedicine services to a intermediary provider where both the telemedicine provider and intermediary provider were part of the same accountable care organization (ACO) but were not otherwise related or subject to a joint operating or affiliation agreement. The participants in the ACO are agreeing to take collective responsibility for the health of the patients assigned to them. Therefore, it seems they could argue that a patient of any provider in the ACO is a patient of all the providers in the ACO.

D. Medical Education

The eTumor Board Conferences could be argued to further medical education in that they allow physicians to learn from specialists about tumor diagnosis and treatment. The selection of cases allows the participating physicians to learn about a far broader range of tumors, and about rare tumors that they might not otherwise encounter in their separate practices. In St. Luke’s, the laboratory tests were performed on samples from real patients because the students needed access to specific cases to get the critical supply of samples and apply the skills they were learning. The same rationale could be used for the eTumor consult. Furthermore, even though the participating doctors may submit cases, they are not assured that their cases will be discussed. Therefore, participation is principally for the educational benefit, not for the value in serving particular patients.

IV. Other Tax Issues with Telemedicine

A. UBIT at State Level

The majority of states impose a tax on the unrelated business income of otherwise tax-exempt organizations. Although there are a variety of approaches, state-level UBIT laws commonly refer to federal tax law to define what is unrelated business taxable income. Some states apply adjustments. If the exempt organization has contacts with multiple states, state law also usually specifies how to apportion the unrelated business income between the state in question and other states.

Apportionment will be the key consideration if a telemedicine activity is generating UBIT and involves contacts with multiple states, as would occur if the patients who are...
benefiting from the services or the client hospitals and health care providers that are purchasing the services are in other states. For many decades, following the development of the Uniform Division of Income for Tax Purposes Act (UDITPA), the factors used for apportionment of income amongst multiple states were payroll, property, and sales. However, as income from services and e-commerce in particular has grown in recent years, states have been varying more from the UDITPA model, and an increasing number of states have moved to a “single sales factor” method. Where telemedicine is concerned, the key question is where the services are considered to be performed as that determines the state where the associated revenue is assigned for purposes of following the state’s approach to allocation. Some states look to where the costs of performance are predominantly incurred (the UDITPA approach). Other states look to where the time is spent performing the services, and a few states look to where the customer is located. The identity of the customer may be unclear. Is the patient the customer? Or is the intermediary provider hospital where the patient is connecting to the telemedicine services the customer? The location might not be the same if the intermediary provider hospital is sending personnel out to where the patient is located in order to connect the patient to a consult. A tax-exempt hospital or other health care provider embarking on telemedicine services will need to determine how the law applies in each state where it has contacts in connection with performing the services in each of the following respects: (a) whether the state applies a state-level UBIT; (b) how the state apportions unrelated business income for purposes of applying the UBIT; and (c) where the state sources income from services when applying its approach to apportionment.

B. International Taxation

A U.S. hospital or health care provider that is exempt from federal income tax under U.S. law would not be subject to U.S. tax on income from a foreign trade or business that is related to its exempt purpose. However, if the trade or business is unrelated, the income is generally included in the provider’s unrelated trade or business income and subject to UBIT. What is not clear is whether or how the income may be taxed by the country or countries where the foreign trade or business is conducted. Under general principles of international taxation, countries can tax income that is sourced in the country even if the party receiving the income is not a citizen or resident of the country. The source of the income is also key to avoiding double taxation in the United States, which allows a foreign tax credit for tax imposed on the foreign source income of U.S. entities. Bilateral tax treaties between different countries also assign taxing jurisdiction based in part on source.

Current U.S. law provides that “compensation for labor or personal services performed in the United States” is generally sourced in the United States, and “compensation for labor or personal services performed without the United States” is foreign sourced. The cases and rulings that have interpreted what it means for services to be performed in the U.S. or outside the U.S. rely heavily on the physical presence of the person performing the personal services to

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9 Id. at 14.

10 IRC § 861(a)(3); § 862(a)(3).
determine whether income from personal services has a U.S. or foreign source. Other countries do not necessarily take the same approach. As Professor Kirsch has observed in his article on the sourcing of personal services (which uses telesurgery as its core example), an approach based on the physical presence of the personal service provider may have made sense when the personal service provider and the personal service recipient were usually in the same place, but it presents significant problems when telecommunications technology allows the service provider and service recipient to be geographically far removed. However, Professor Kirsch observes that sourcing the income of a U.S. health care provider performing telemedicine services in the U.S. would not be problematic “[b]ecause most countries currently source personal services income based on the location of the service provider, the foreign country probably would view this income as foreign source (from its perspective) because the surgeon is located in the United States. As a result, the foreign country would be unlikely to exercise source-based taxation on the U.S. surgeon’s income even though the patient is in that country.”

In sum, because U.S. law taxes hospitals and health care providers formed under U.S. law on their worldwide income, they should start with the initial assumption that income received from providing telemedicine services to patients and providers abroad will be subject to tax to the same extent the income would be if the services were provided to U.S. patients and providers. Furthermore, they should also start with the assumption that the income from the services will be treated as having a U.S. source for U.S. income tax purposes, creating an obstacle to claiming a U.S. foreign tax credit should the foreign jurisdiction impose income tax. These are initial assumptions, and the specifics of any particular activity or transaction would need to be analyzed. For example, there may be a questions as to whether any portion of the income is income from something other than personal services, such as income from intellectual property. The U.S. entity will also need to check the specific laws of the relevant foreign countries to determine whether they source the income based on where the physician is present or where the patient is present. Finally, the U.S. entity will want to research whether the U.S. has bilateral income tax treaties with the relevant foreign countries that may govern the taxation of the income and potentially vary from the treatment they can most likely expect under U.S. income tax law.

C. Other State Level Taxes

Virtually all states impose a tax on revenue from the provision of medical services to help fund the state’s Medicaid program. In many states, the terms of the tax vary depending on the


12 Kirsch, 1057.

type of provider. For example, Minnesota taxes hospitals on patient revenues at a 1.56% rate and it taxes managed care organizations on net premium revenues at a 1.6% rate. Thus, the health care provider will have to determine whether revenue from telemedicine services is in the tax base for the provider tax.

State sales and use tax may also apply if the telemedicine services are an unrelated trade or business. For taxable health care providers, state sales and use taxes may have broad application. For tax-exempt health care providers, many states impose (1) sales tax on an organization’s sales of supplies and equipment sold as part of an unrelated trade or business and (2) use tax on an organization’s purchase of supplies and equipment for use in an unrelated trade or business. (Use tax is owed if the seller does not collect sales tax.) To the extent telemedicine activities are viewed as unrelated trades or businesses, tax-exempt providers of the services will want to check the application of state sales tax to sales of supplies and equipment to intermediaries or recipients of the services, and state sales and use tax to purchases of supplies and equipment used to deliver the services.