
— TELEHEALTH LITIGATION

The Standard of Care on a Screen

Telehealth Visits, Remote Prescribing, and What the Record Should Show

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Telehealth isn't going anywhere. On February 3, 2026, the Consolidated Appropriations Act extended Medicare's telehealth flexibilities, including visits from home and audio-only services, through the end of 2027. DEA and HHS extended the rules that let clinicians prescribe controlled substances by telemedicine without first seeing the patient in person through December 31, 2026, while a permanent framework, including a special telemedicine registration proposed in January 2025, is still being worked out.

Prosecutors are paying attention too. In November 2025, a federal jury in San Francisco convicted the founder and the clinical president of Done Global in what DOJ called the first federal drug distribution prosecution of a digital health company. The government said the company pushed tens of millions of Adderall and other stimulant pills through short visits and automatic refills. In July 2026, the founder got six years and the clinical president two. That case was about alleged deliberate misconduct on a huge scale, and ordinary telehealth looks nothing like it. But it has made everyone look harder at how remote prescribing decisions get made and written down.

In civil cases, the question is almost never whether telehealth was used. It's whether a screen was the right place for this particular problem, and whether anyone noticed when it wasn't.

SAME STANDARD, DIFFERENT TOOLS

The Federation of State Medical Boards' position, which most state boards share, is that a telemedicine visit is held to the same standard of care as an in-person one. If you choose to see a patient on video, you take on the same duty you'd have in an exam room.

That has a practical edge. If a complaint needs a hands-on exam, a test, or a procedure that can't happen over video, the clinician has to arrange it, or at least recognize the limit and tell the patient plainly. Telehealth changes how you meet the standard. Sometimes it means you can't meet it without getting the patient in the door.

A FICTIONAL CASE

He's 44 and books a video urgent care visit for low back pain after lifting something heavy. Along the way he mentions numbness "down there" and that he had trouble peeing that morning. The clinician calls it a strain, prescribes a muscle relaxant and an anti-inflammatory, and says to follow up if it doesn't get better. Three days later he's in an ER with cauda equina syndrome and goes to surgery. He's left with lasting bladder and nerve problems.

RED FLAGS DON'T CARE WHAT THE VISIT TYPE IS

Numbness in the saddle area and new trouble urinating are classic warning signs of cauda equina syndrome. They call for an urgent in-person exam and an MRI, however the visit started. So the questions are simple: did the clinician ask about them, write them down, and do anything with them?

The same thing happens across medicine. Chest pain, new neurological symptoms, a sudden severe headache or vision loss, bad abdominal pain with fever, signs of infection in someone frail or immunosuppressed, shortness of breath with low oxygen, suicidal thoughts with a plan, fever in a young infant: each of those can outrun what a remote visit can safely handle. Most telehealth services have written exclusion and escalation lists for exactly these situations. Get the list and compare it to what happened.

WHAT A GOOD TELEHEALTH NOTE TELLS YOU

It should say what kind of visit it was (video, phone, or message), because that defines what the clinician could actually see and hear. It should say where the patient was. That matters for licensure, since clinicians generally need a license in the state where the patient is sitting, and it matters if someone needs to send an ambulance. Any exam should be described honestly as a limited remote exam ("patient demonstrated forward flexion to approximately 30 degrees"), not dressed up as a complete one.

The return precautions should be specific. "Go to the ER right away if you get numbness, weakness, or trouble urinating" and "follow up if not improving" are very different instructions, and the difference matters more when nobody has laid hands on the patient. And the note should show whether prior records were reviewed and whether the patient's regular doctor was told. Telehealth fragments care easily, and a string of visits for the same complaint, each treated as brand new, is a pattern worth noticing.

The platform itself usually holds more than the note: intake questionnaires, chat transcripts, how long the visit lasted, how long the patient waited, sometimes a recording. The intake form is often where the patient first typed out the symptom that mattered. Retention varies by platform, so address preservation early.

PHONE-ONLY VISITS AND MESSAGES

Audio-only visits are still covered for many services, and for patients without good video they're a lifeline. But they strip out everything visual: color, breathing effort, facial droop, how sick someone looks. Ask whether the problem could reasonably be handled without seeing the patient at all.

Portal messages and questionnaire-based visits bring a different risk: time. A message sent Friday night may sit until Monday. Rebuild it: when it was sent, what it said, who read it and when, and what came back. Most organizations have policies on response times and on how to triage urgent symptoms that come in by message. Portal messages and their metadata often aren't in a standard records production, so ask for them by name.

CONTROLLED SUBSTANCES

The Ryan Haight Act of 2008 generally requires an in-person evaluation before controlled substances are prescribed over the internet, with some exceptions. The temporary flexibilities set that aside through the end of 2026, and DEA separately finalized a rule in January 2025 on telemedicine prescribing of buprenorphine for opioid use disorder. None of that relaxes the clinical duty.

For a remote prescription of a stimulant, a benzodiazepine, an opioid, or buprenorphine, look at what the diagnosis rested on: a structured assessment, validated screening tools, prior records, anyone else's account. Look for the PDMP check, which many states require before certain prescriptions. Look for a risk assessment covering substance use history, other sedatives, and heart risk with stimulants. Look for a follow-up plan and for how refills were handled: who approved them, after what review, how fast. If the claim is against the platform, visit length and prescribing volume can matter a great deal.

THE COMPANY BEHIND THE SCREEN

Many platforms contract with their clinicians instead of employing them, and what that means for the platform's liability is for counsel. Clinically, you can still look at what the company built: its protocols, escalation paths, training, supervision and quality review, its note templates, its visit-length targets, whether pay was tied to volume, and whether refills were automated. A platform designed in a way that made red flags easy to miss is a different case from one with good protocols that a single clinician ignored.

CAUSATION

In our case, the question is whether an in-person exam and MRI on the day of the video visit would probably have gotten him to surgery sooner and left him better off. Timing matters a lot in cauda equina, particularly whether urinary retention had become complete before surgery, but how much a particular delay mattered is a question for a spine surgeon. And pin down when the symptoms actually appeared. Symptoms that started after the visit make for a very different case than symptoms he described and nobody acted on.

RECORDS WORTH REQUESTING

- The full telehealth encounter, including the intake questionnaire and any messages before the visit
- Platform metadata: start and end times, visit type, queue time, clinician location
- Chat transcripts, portal messages, and any triage notes attached to them
- Recordings, if any were kept
- Prescription records, PDMP query logs, and pharmacy dispensing records
- The platform's clinical protocols, exclusion criteria, and escalation policies in effect that day
- The clinician's license for the patient's state, and the contract and supervision arrangements
- Everything after: in-person visits, ER, imaging, surgery

SOURCES

- Consolidated Appropriations Act, 2026 (signed Feb. 3, 2026); Baker Donelson, “Medicare Telehealth Waivers Extended for Several More Years”
- HHS and DEA, fourth temporary extension of telemedicine flexibilities for prescribing controlled medications (through Dec. 31, 2026)
- DEA, *Special Registrations for Telemedicine and Limited State Telemedicine Registrations*, proposed rule (Jan. 17, 2025)
- Ryan Haight Online Pharmacy Consumer Protection Act of 2008, 21 U.S.C. § 829(e)
- DOJ and IRS-CI releases on *United States v. He and Brody* (N.D. Cal.) (convictions Nov. 2025); Telehealth.org, “Done Global Founder Sentenced” (July 2026)
- Federation of State Medical Boards, *The Appropriate Use of Telemedicine Technologies in the Practice of Medicine* (2022)

This newsletter is for education only and isn't medical or legal advice. The case is fictional. Licensure and prescribing rules vary by state.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a telehealth case and want to know whether the screen was the right place for the problem, and what the platform's own records show, we'd welcome the conversation.

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