Telemedicine Workgroup
August 5, 2019
Table of Contents

Telemedicine Workgroup

Department of Health Professions
9960 Mayland Drive, Henrico VA
Second Floor, Board Room 4
August 5, 2019
10:00 AM – 2:00 PM

1. **Call to Order of Meeting**
2. **Introductions**
3. **Public Comment**
4. **Overview and Background**
5. **Regulatory Issues**
6. **Reimbursement Issues**
7. **Other Issues**
8. **Next Steps**
9. **Adjourn**

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

ROBERT D. "BOBBY" ORROCK
POST OFFICE BOX 458
THORNBURG, VIRGINIA 22565

FIFTY-FOURTH DISTRICT

May 21, 2019

COMMITTEE ASSIGNMENTS
HEALTH, WELFARE AND INSTITUTIONS (CHAIRMAN)
FINANCE
AGRICULTURE, CHESAPEAKE AND NATURAL RESOURCES
RULES

Dr. David Brown, DC
Director, Virginia Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Re: House Bill 2128 - Telemedicine

Dear Dr. Brown,

During the 2019 Session, the House Committee on Health, Welfare and Institutions considered HB 2128 (Guzman). That bill would have authorized a person licensed to practice medicine or osteopathy who is in good standing with the applicable regulatory agency of a jurisdiction contiguous to the Commonwealth to provide health care services to patients located in the Commonwealth through use of telemedicine service. HB 2128 was tabled in the committee with a request that the Department of Health Professions study the issue.

On behalf of HWI, I am requesting that the Department of Health Professions undertake a review of the practice of telemedicine in the Commonwealth and develop recommendations for changes to laws and regulations governing the practice of telemedicine to maximize access to health care while protecting the health and wellbeing of citizens of the Commonwealth. I ask that you report back to the House Committee on the progress of such study and any recommendations it may have elicited by November 1, 2019. I also ask that you take steps to ensure participation of appropriate stakeholders in the process of conducting this study.

Sincerely,

Robert D. "Bobby" Orrock, Sr.,
Chairman, HWI

cc: The Honorable Elizabeth Guzman
W. Scott Johnson, Esq.

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

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FIFTY-FOURTH DISTRICT

COMMITTEE ASSIGNMENTS:
HEALTH, WELFARE AND INSTITUTIONS (CHAIRMAN)
FINANCE
AGRICULTURE, CHESAPEAKE AND NATURAL RESOURCES
RULES

May 28, 2019

Dr. David Brown, DC
Director, Virginia Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Re: House Bill 1970 - Telemedicine

Dear Dr. Brown:

During the 2019 General Assembly Session, the House Committee on Health, Welfare and Institutions heard and reported House Bill 1970 (Kilgore) with a substitute. The bill was enacted by the Governor on March 5, 2019. The enacted bill (i) requires insurers, corporations, or health maintenance organizations to cover medically necessary remote patient monitoring services as part of their coverage of telemedicine services to the full extent that these services are available; (ii) defines remote patient monitoring services as the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload; and (iii) requires the Board of Medical Assistance Services to include in the state plan for medical assistance services a provision for the payment of medical assistance for medically necessary health care services provided through telemedicine services.

The bill as originally introduced included a provision stating that the practice of telemedicine is deemed to occur where the practitioner is located at the time of provision of services. Delegate Kilgore agreed to remove this provision from the legislation with the understanding that I would request that the Department of Health Professions study and determine the appropriate application of state laws and regulations to the practice of telemedicine.

On behalf of the House Committee on Health, Welfare and Institutions, I write to request that the Department of Health Professions study and determine whether the laws and regulations of the Commonwealth or the laws and regulations of the jurisdiction within which the practitioner is located at the time of provision of services should apply to telemedicine services

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rendered to patients located in the Commonwealth. I ask that you report back to the House Committee with your findings by October 1, 2019.

Sincerely,

Robert D. "Bobby" Orrock, Sr.
Chairman, HWI

cc: The Honorable Terry Kilgore
W. Scott Johnson, Esquire

HB 1970 (Kilgore) and SB 1221 (Chafin)

Affecting 32.1-325 (Medicaid)
and 38.2-3418.16 (Insurance)

Be it enacted by the General Assembly of Virginia:
1. That §§ 32.1-325 and 38.2-3418.16 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.
A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time, and submit to the U.S. Secretary of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

26. A provision for the payment of medical assistance for medically necessary health care services provided through telemedicine services.

§ 38.2-3418.16. Coverage for telemedicine services.
A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.
B. As used in this section~~, "telemedicine services,"~~:
"Remote patient monitoring services" means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.
"Telemedicine services" as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, *providing remote patient monitoring services,* or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.
C. An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.
D. An insurer, corporation, or health maintenance organization shall not be required to reimburse the treating provider or the consulting provider for technical fees or costs for the provision of telemedicine services; however, such insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through face-to-face consultation or contact.

E. Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require pre-authorization of emergent telemedicine services.

F. An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through face-to-face diagnosis, consultation, or treatment.

G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

H. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2011, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

I. This section shall not apply to short-term travel, accident-only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

J. The coverage required by this section shall include the use of telemedicine technologies as it pertains to medically necessary remote patient monitoring services to the full extent that these services are available.

The following bills, introduced in the 2019 General Assembly Session, contained telemedicine provisions that would have required a medical license where the provider is located, instead of where the patient is located. These provisions did not pass, with the understanding that instead this workgroup would be convened.

HB 1970 (Kilgore) and SB 1221 (Chafin) – provisions were struck

§ 54.1-2901. Exceptions and exemptions generally.
A. The provisions of this chapter shall not prevent or prohibit:
33. Any practitioner of one of the professions regulated by the Board of Medicine who is located in another state and is in good standing with the applicable regulatory agency in such state from providing telemedicine services within the scope of his practice, as defined in § 38.2-3418.16, to a patient located in Virginia.

§ 54.1-2903. What constitutes practice; location of practice.
C. In cases in which a practitioner of the healing arts is providing telemedicine services, such practice is deemed to occur where the practitioner is located at the time of provision.

HB 2128 (Guzman) and SB 1124 (Favola) – bills were withdrawn

§ 54.1-2901. Exceptions and exemptions generally.
A. The provisions of this chapter shall not prevent or prohibit:
33. Any person licensed to practice medicine or osteopathy who is in good standing with the applicable regulatory agency of a jurisdiction that is contiguous with the Commonwealth from providing health care services to patients located in the Commonwealth through use of telemedicine services as defined in § 38.2-3418.16.

Virginia Board of Medicine

Telemedicine

Section One: Preamble.

The Virginia Board of Medicine ("Board") recognizes that using telemedicine services in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these services can enhance medical care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice. With the exception of prescribing controlled substances, the Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services. The Board issues this guidance document to assist practitioners with the application of current laws to telemedicine service practices.

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. For the purpose of prescribing controlled substances, a practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303. A practitioner should conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine services in the practice of medicine. The Board is committed to ensuring patient access to the convenience and benefits afforded by telemedicine services, while promoting the responsible provision of health care services.

It is the expectation of the Board that practitioners who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the applicable profession;
- Adhere to applicable laws and regulations;

- In the case of physicians, properly supervise non-physician clinicians when required to do so by statute; and
- Protect patient confidentiality.

Section Two: Establishing the Practitioner-Patient Relationship.

The practitioner-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship. Where an existing practitioner-patient relationship is not present,[1] a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law.[2] While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.

A practitioner is discouraged from rendering medical advice and/or care using telemedicine services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine services. An appropriate practitioner-patient relationship has not been established when the identity of the practitioner may be unknown to the patient.

Section Three: Guidelines for the Appropriate Use of Telemedicine Services.
The Board has adopted the following guidelines for practitioners utilizing telemedicine services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.

Licensure:

The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

Evaluation and Treatment of the Patient:

[1] This guidance document is not intended to address existing patient-practitioner relationships established through in-person visits.

[2] The practitioner must adhere not only to Virginia law defining a practitioner-patient relationship, but the law in any state where a patient is receiving services that defines the practitioner-patient relationship.

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, which treatment includes the issuance of prescriptions, electronically or otherwise. 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, in-person encounters. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:

Evidence documenting appropriate patient informed consent for the use of telemedicine services must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following:

- Identification of the patient, the practitioner, and the practitioner's credentials;
- Types of activities permitted using telemedicine services (e.g. prescription refills, appointment scheduling, patient education, etc.);
- Agreement by the patient that it is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine services, such as encrypting date of service, password protected screen savers, encrypting data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-practitioner communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine services. Informed consents obtained in connection with an encounter involving telemedicine services should also be filed in the medical record. The patient record established during the use of telemedicine services must be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records and Exchange of Information:

Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using telemedicine services. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the

communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Section Four: Prescribing:

Prescribing controlled substances requires the establishment of a bona fide practitioner-patient relationship in accordance with § 54.1-3303 (A) of the Code of Virginia. Prescribing controlled substances, in-person or via telemedicine services, is at the professional discretion of the prescribing practitioner. The indication, appropriateness, and safety considerations for each prescription provided via telemedicine services must be evaluated by the practitioner in accordance with applicable law and current standards of practice and consequently carries the same professional accountability as prescriptions delivered during an in-person encounter. Where such measures are upheld, and the appropriate clinical consideration is carried out and documented, the practitioner may exercise their judgment and prescribe controlled substances as part of telemedicine encounters in accordance with applicable state and federal law.

Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A). Prescribing controlled substances in Schedule II through V via telemedicine also requires compliance with federal rules for the practice of telemedicine. Practitioners issuing prescriptions as part of telemedicine services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship.

For the purpose of prescribing Schedule VI controlled substances, "telemedicine services" is defined as it is in § 38.2-3418.16 of the Code of Virginia. Under that definition, *"telemedicine services," as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.*

Section Five: Guidance Document Limitations.

Nothing in this document shall be construed to limit the authority of the Board to investigate, discipline, or regulate its licensees pursuant to applicable Virginia statutes and regulations. Additionally, nothing in this document shall be construed to limit the Board's ability to review the delivery or use of telemedicine services by its licensees for adherence to the standard of care and compliance with the requirements set forth in the laws and regulations of the Commonwealth of Virginia. Furthermore, this document does not limit the Board's ability to determine that certain situations fail to meet the standard of care or standards set forth in laws and regulations despite technical adherence to the guidance produced herein.

Statutory references:

§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only.

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, or by a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32.

B. A prescription shall be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship or veterinarian-client-patient relationship.

A bona fide practitioner-patient relationship shall exist if the practitioner has (i) obtained or caused to be obtained a medical or drug history of the patient; (ii) provided information to the patient about the benefits and risks of the drug being prescribed; (iii) performed or caused to be performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically; and (iv) initiated additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects. Except in cases involving a medical emergency, the examination required pursuant to clause (iii) shall be performed by the practitioner prescribing the controlled substance, a practitioner who practices in the same group as the practitioner prescribing the controlled substance, or a consulting practitioner. In cases in which the practitioner is an employee of the Department of Health and is providing expedited partner therapy consistent with the recommendations of the Centers for Disease Control and Prevention, the examination required by clause (iii) shall not be required.

A practitioner who has established a bona fide practitioner-patient relationship with a patient in accordance with the provisions of this subsection may prescribe Schedule II through VI controlled substances to that patient, provided that, in cases in which the practitioner has performed the examination required pursuant to clause (iii) by use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically, the prescribing of such Schedule II through V controlled substance is in compliance with federal requirements for the practice of telemedicine.

For the purpose of prescribing a Schedule VI controlled substance to a patient via telemedicine services as defined in § 38.2-3418.16, a prescriber may establish a bona fide practitioner-patient relationship by an examination through face-to-face interactive, two-way, real-time communications services or store-and-forward technologies[3] when all of the following conditions are met: (a) the patient has provided a medical history that is available for review by the prescriber; (b) the prescriber obtains an updated medical history at the time of prescribing; (c) the prescriber makes a diagnosis at the time of prescribing; (d) the prescriber conforms to the standard of care expected of in-person care as appropriate to the

[3] Although the term "store-and-forward technologies" is not defined by statute, it is defined by regulation of the Virginia Department of Health for the purpose of Medicare and Medicaid covered services, as: "'store and forward' means when prerecorded images, such as x-rays, video clips, and photographs are captured and then forwarded to and retrieved, viewed, and assessed by a provider at a later time. Some common applications include (i) teledermatology, where digital pictures of a skin problem are transmitted and assessed by a dermatologist; (ii) teleradiology, where x-ray images are sent to and read by a radiologist; and (iii) teleretinal imaging, where images are sent to and evaluated by an ophthalmologist to assess for diabetic retinopathy." 12 VAC 30-121-70(7)(a).

patient's age and presenting condition, including when the standard of care requires the use of diagnostic testing and performance of a physical examination, which may be carried out through the use of peripheral devices appropriate to the patient's condition; (e) the prescriber is actively licensed in the Commonwealth and authorized to prescribe; (f) if the patient is a member or enrollee of a health plan or carrier, the prescriber has been credentialed by the health plan or carrier as a participating provider and the diagnosing and prescribing meets the qualifications for reimbursement by the health plan or carrier pursuant to § 38.2-3418.16; and (g) upon request, the prescriber provides patient records in a timely manner in accordance with the provisions of § 32.1-127.1:03 and all other state and federal laws and regulations. Nothing in this paragraph shall permit a prescriber to establish a bona fide practitioner-patient relationship for the purpose of prescribing a Schedule VI controlled substance when the standard of care dictates that an in-person physical examination is necessary for diagnosis. Nothing in this paragraph shall apply to: (1) a prescriber providing on-call coverage per an agreement with another prescriber or his prescriber's professional entity or employer; (2) a prescriber consulting with another prescriber regarding a patient's care; or (3) orders of prescribers for hospital out-patients or in-patients.

Any practitioner who prescribes any controlled substance with the knowledge that the controlled substance will be used otherwise than medicinally or for therapeutic purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the distribution or possession of controlled substances.

§ 54.1-3408.01. Requirements for prescriptions.

A. The written prescription referred to in § 54.1-3408 shall be written with ink or individually typed or printed. The prescription shall contain the name, address, and telephone number of the prescriber. A prescription for a controlled substance other than one controlled in Schedule VI shall also contain the federal controlled substances registration number assigned to the prescriber. The prescriber's information shall be either preprinted upon the prescription blank, electronically printed, typewritten, rubber stamped, or printed by hand.

The written prescription shall contain the first and last name of the patient for whom the drug is prescribed. The address of the patient shall either be placed upon the written prescription by the prescriber or his agent, or by the dispenser of the prescription. If not otherwise prohibited by law, the dispenser may record the address of the patient in an electronic prescription dispensing record for that patient in lieu of recording it on the prescription. Each written prescription shall be dated as of, and signed by the prescriber on, the day when issued. The prescription may be prepared by an agent for the prescriber's signature.

This section shall not prohibit a prescriber from using preprinted prescriptions for drugs classified in Schedule VI if all requirements concerning dates, signatures, and other information specified above are otherwise fulfilled.

No written prescription order form shall include more than one prescription. However, this provision shall not apply (i) to prescriptions written as chart orders for patients in hospitals and long-term-care facilities, patients receiving home infusion services or hospice patients, or (ii) to a prescription ordered through a pharmacy operated by or for the Department of Corrections or the Department of Juvenile Justice, the central pharmacy of the Department of Health, or the central outpatient pharmacy operated by the Department of Behavioral Health and Developmental Services; or (iii) to prescriptions written for patients residing in adult and juvenile detention centers, local or regional jails, or work release centers operated by the Department of Corrections.

B. Prescribers' orders, whether written as chart orders or prescriptions, for Schedules II, III, IV, and V controlled drugs to be administered to (i) patients or residents of long-term care facilities served by a Virginia pharmacy from a remote location or (ii) patients receiving parenteral, intravenous, intramuscular, subcutaneous or intraspinal infusion therapy and served by a home infusion pharmacy from a remote location, may be transmitted to that remote pharmacy by an electronic communications device over telephone lines which send the exact image to the receiver in hard copy form, and such facsimile copy shall be treated as a valid original prescription order. If the order is for a radiopharmaceutical, a physician authorized by state or federal law to possess and administer medical radioactive materials may authorize a nuclear medicine technologist to transmit a prescriber's verbal or written orders for radiopharmaceuticals.

C. The oral prescription referred to in § 54.1-3408 shall be transmitted to the pharmacy of the patient's choice by the prescriber or his authorized agent. For the purposes of this section, an authorized agent of the prescriber shall be an employee of the prescriber who is under his immediate and personal supervision, or if not an employee, an individual who holds a valid license allowing the administration or dispensing of drugs and who is specifically directed by the prescriber.

FEDERATION OF STATE MEDICAL BOARDS

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup

Adopted as policy by the Federation of State Medical Boards in April 2014

INTRODUCTION

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the "Model Guidelines for the Appropriate Use of the Internet in Medical Practice" (HOD 2002)[1] and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards") based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients[2] via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

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[1] *The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Model Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).*

[2] *The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.*

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Model Guidelines for State Medical Boards' Appropriate Regulation of Telemedicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider.[3] However, state medical boards, in fulfilling their duty to protect the public, face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the prescribing and dispensing of certain medications.

The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these technologies can enhance medical care by facilitating communication with physicians and their patients or other health care providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice.[4]

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.[5]

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;

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[3] *See Center for Telehealth and eHealth Law (Ctel), http://ctel.org/ (last visited Dec. 17, 2013).*

[4] *Id.*

[5] *See Cal. Bus. & Prof. Code § 2290.5(d).*

- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

Section Two. Establishing the Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.[6] The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

Section Three. Definitions

For the purpose of these guidelines, the following definitions apply:

"Telemedicine" means 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. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.[7]

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.

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[6] *American Medical Association, Council on Ethical and Judicial Affairs, Fundamental Elements of the Patient-Physician Relationship (1990), available at http://www.ama-assn.org/resources/doc/code-medical-ethics/1001a.pdf.*

[7] *See Ctel.*

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Section Four. Guidelines for the Appropriate Use of Telemedicine Technologies in Medical Practice

The [Name of Board] has adopted the following guidelines for physicians utilizing telemedicine technologies in the delivery of patient care, regardless of an existing physician-patient relationship prior to an encounter:

Licensure:
A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.[8]

Establishment of a Physician-Patient Relationship:
Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship consistent with the guidelines identified in Section Two, and, while each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.

Evaluation and Treatment of the Patient:
A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. 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. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:
Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician's credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

[8] *Federation of State Medical Boards, A Model Act to Regulate the Practice of Medicine Across State Lines (April 1996), available at http://www.fsmb.org/pdf/1996_grpol_telemedicine.pdf.*

Continuity of Care:
Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient, and subject to the patient's consent, any identified care provider of the patient immediately after the encounter.

Referrals for Emergency Services:
An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

Medical Records:
The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records & Exchange of Information:
Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information," issued by the Department of Health and Human Services (HHS).[9] Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional face-to-face encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory

[9] *45 C.F.R. § 160, 164 (2000).*

results must be secure within existing technology (i.e. password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:
Online services used by physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated physicians;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Online services used by physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the site and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Advertising or promotion of goods or products from which the physician receives direct remuneration, benefits, or incentives (other than the fees for the medical care services) is prohibited. Notwithstanding, online services may provide links to general health information sites to enhance patient education; however, the physician should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, physicians should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of preferred relationships with any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit form that pharmacy.

Prescribing:
Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by [Name of Board].

Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

Section Five. Parity of Professional and Ethical Standards
Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC). There should be parity of ethical and professional standards applied to all aspects of a physician's practice.
A physician's professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies.

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MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

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What is Telehealth?

Context for Framing Your Perspective

Aug. 2018

As state and federal policymakers, government agencies, insurers, practitioners, and consumers expanded the opportunities for telehealth, a wide range of terms and definitions have emerged. Unfortunately, there are very few universal definitions and many terms are interchangeable. There are several general themes that can be used to describe your "telehealth initiative."

COMMON TELEHEALTH DEFINITIONS

AMERICAN TELEMEDICINE ASSOCIATION (ATA):

[...] is the remote delivery of health care services and clinical information using telecommunications technology[...]

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA):

[...] defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care[...]

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS):

[...] In general, these "Telehealth Services" require the use of an interactive audio and video telecommunications system for real-time communication between a provider and beneficiary who must to be located at a rural health care facility. InJuly 2018, CMS proposed new services with "Remote Communication Technology," including virtual check-ins and remote evaluation of pre-recorded patient information[...]

NATIONAL CONSORTIUM OF TELEHEALTH RESOURCE CENTERS

The NCTRC acknowledges the various definitions of telehealth. The purpose of this fact sheet is to encompass all the varying ways to interpret telehealth rather than providing a hardline definition. For instance, a payer would view telehealth differently from an insurance company, yet the two are still intertwined.

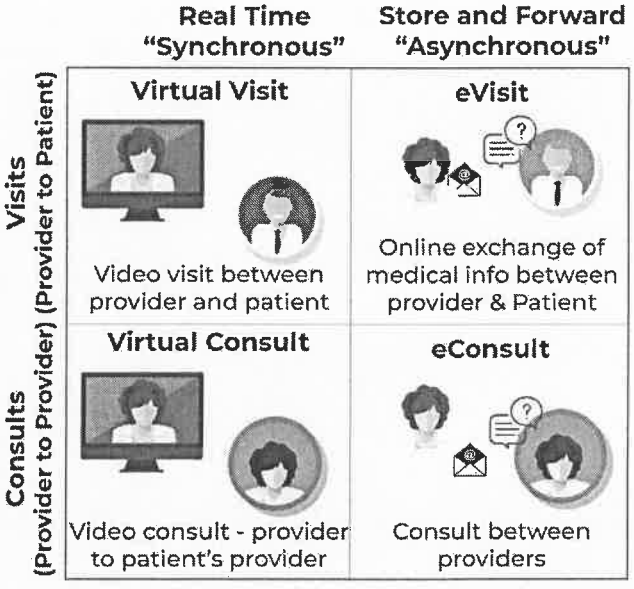
3 important contexts are outlined to expand your perspective to see telehealth as an integrative tool that connects healthcare.

Understanding telehealth from the perspective that applies to you:

1. TYPES OF TELEHEALTH TECHNOLOGY

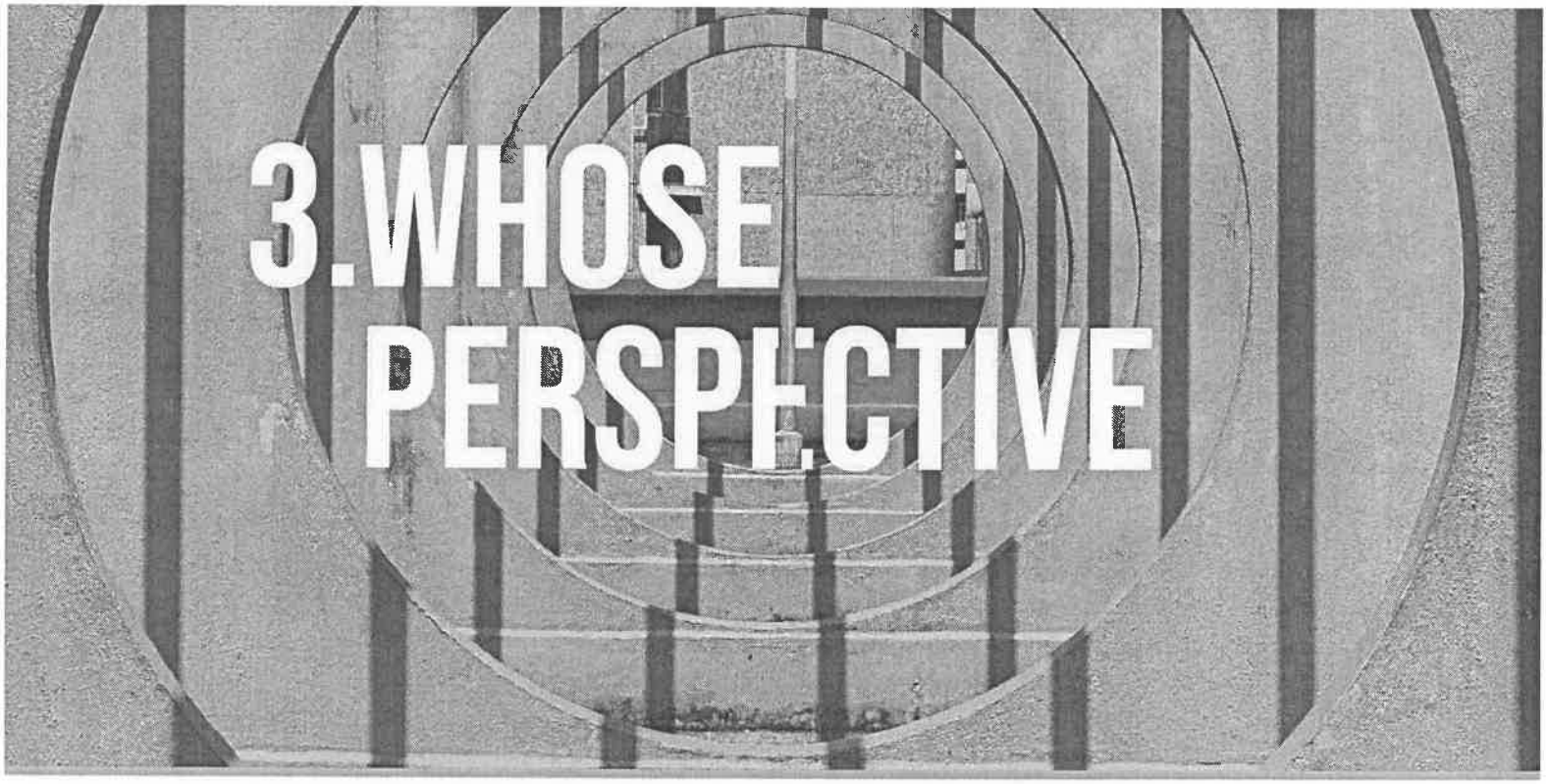
There are four main categories of telecommunications technologies that are used for telehealth: synchronous, asynchronous, RPM*, and mHealth. What type of connection(s) will your telehealth program make?

2. WHEN AND BETWEEN WHO?**



**Reproduced with permission from the MGH Center for Telehealth

*Remote Patient Monitoring (RPM) is a modality that monitors physiology and behavior to maintain best function in the least restrictive, least expensive, or most preferred environment.



3. WHOSE PERSPECTIVE

Telehealth can be viewed from multiple perspectives. For example, a clinician and patient might focus on convenience and clinical effectiveness, while hospitals and insurers would might be more interested in utilization and meeting needs across an entire region. Each perspective is important, but none provides the entire picture.

EACH PARTY COULD EMPHASIZE DIFFERENT ASPECTS OF TELEHEALTH IN A DEFINITION.

PATIENT HEALTH SYSTEM
HOSPITAL CLINICIAN
COMMUNITY PAYER CLINIC

We don't have to use the same definition of telehealth.

CONNECT

www.telehealthresourcecenter.org

NCTRC & TheNCTRC

KEY QUESTIONS TO ASK:

As you look to describe your telehealth initiative, consider these questions:

- Who is providing and receiving the service?
- Is it a clinical service, a professional consultation, or an education/training?
- In what context is the service being provided? Is it in a hospital, clinic, patient's home/residence, or other facilities?
- Is it synchronous or asynchronous?
- What type of technology is being used?
- How is the service funded? Is it billable to insurance or supported by some other arrangement?
- How does this service fit into any established definitions in your state laws, regulations, etc.

FOUR CRITICAL DIFFERENTIATORS:

1. Direct Patient services vs other health-related activities
2. Live vs Store and Forward (synchronous vs asynchronous)
3. Clinic or hospital-based vs direct to consumer
4. Billable (direct or monthly) vs Patient Self-pay vs unbillable value generation

The National Consortium of Telehealth Resource Centers (NCTRC) is an affiliation of the 14 Telehealth Resource Centers funded individually through cooperative agreements from the Health Resources & Services Administration, Office for the Advancement of Telehealth. The goal of the NCTRC is to increase the consistency, efficiency, and impact of federally funded telehealth technical assistance services. This Framing Telehealth fact sheet was made possible by 14 Telehealth Resource Centers and administered through grant#G22RH30365 from the Office for the Advancement of Telehealth, Federal Office of Rural Health Policy, Health Resources and Services Administration, Department of Health and Human Services.

The ubiquitous adoption of telehealth continues to lag despite improved technology and increasing amounts of evidence of its ability to effectively provide health services. In the last few years telehealth has received attention as a means to achieving the goals of the Triple Aim: increased efficiency, better health outcomes, and better care. However, existing policy barriers on both federal and state levels contribute to the limited use of telehealth. Below are some of the major barriers that currently exist.

REIMBURSEMENT

Telehealth reimbursement policy varies greatly on the federal and state levels. Restrictions in the Medicare program include limitations on where telehealth services may take place, both geographically and facility-wise (although there are some exceptions for certain conditions), the limited number of providers who may bill for services delivered via telehealth, a limited list of services that can be billed, and restricting, for the most part, to only allowing live video to be reimbursed. In 2019, CMS did expand reimbursement to include remote communication technology, remote physiological monitoring and chronic care management reimbursement as services separate from "telehealth", so as not to necessitate the application of all of the rules and restrictions that telehealth delivered services are subject to. On the Medicaid side, each state dictates what their Medicaid telehealth policies are which creates a patchwork quilt of telehealth laws and regulations across the nation.

Over the last few years, states have also begun to pass legislation to either encourage or mandate private payers to reimburse for telehealth delivered services. These policies also vary across states and some contain their own limitations, depending on how the laws have been crafted. Additionally, the laws may also be written in such a way where there may be parity in coverage of services, but not necessarily parity in payment amount. In other words, a state law may require an insurer to pay for services if they are delivered via telehealth if those same services were covered if delivered in-person, but the law may not require the insurer to necessarily pay the same amount for that service in both cases.

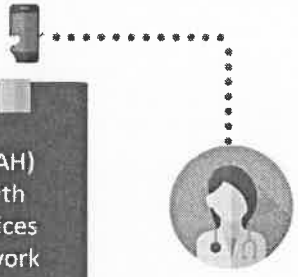
LICENSING/REGULATORY BOARDS

Licensing is under the purview of states to control and regulate. The majority require a license from the state in order to provide services though a few exceptions exists in a few jurisdictions. Various national groups have worked to ease some of these issues. The enhanced Nurses Licensing Compact allows a nurse with a license in a compact member state to practice in another compact member state without having to obtain another state license. The Federation of State Medical Boards offered their own type of solution for physicians by creating model language for an Interstate Medical Licensure Compact that allows member states to create an expedited process to obtain a license in member states. There is also the Physical Therapy Interstate Licensure Compact, the Psychologist Interjurisdictional Compact (PSYPACT), and the Recognition of EMS Personnel Licensure Interstate CompAct (REPLICA).

In addition to the licensing issue, regulatory boards also hold key control over other aspects that impact telehealth policy. Increasingly, regulatory boards are looking to develop regulations, policies, or guidelines on how providers they regulate utilize telehealth in their practices. Some of these guidelines have mirrored what licensees would need to do if they had provided the services in-person, others have included additional requirements.

CREDENTIALING/PRIVILEGING

CMS approved regulations to allow hospitals and critical access hospitals (CAH) to credential by proxy which allows a clinic (the originating site) to contract with another hospital, CAH or telemedicine entity (the distant site) to provide services via telehealth and credential those providers by relying on the credentialing work done by the distant site, if certain conditions are met. This creates a faster, more cost effective method for clinics and hospitals to access needed specialty care. The Joint Commission created parallel guidelines to the federal regulations. Both are optional to use and a clinic or hospital may still utilize a full credentialing process.

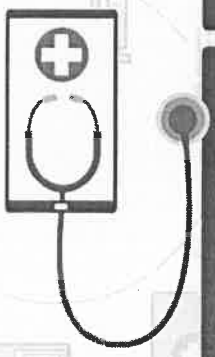


Delivering medical care at a distance

PRESCRIBING

The Ryan Haight Act dictates how telehealth (telemedicine is the term used in the Act) may be used to prescribe controlled substances. The Act provides specific scenarios on how the interaction between patient and provider must take place. The onset of the opioid epidemic and potential for telehealth to be used to deliver aspects of Medication Assisted Therapy (MAT), which can involve prescribing controlled substances, has sparked interest in creating some exceptions to the prescribing requirements under the Ryan Haight Act. In the 2018 legislative session, HR 6, the SUPPORT for Patients and Communities Act was signed into law, which requires the Attorney General (AG) to promulgate final regulations to specify the limited circumstances in which a telemedicine special registration may be issued to prescribe controlled substances and the procedure for obtaining a special registration within a year of enactment.

States have control over how everything else is prescribed (except controlled substances) when telehealth is used and the policies vary across states. A relationship entirely built via telehealth may not be considered a valid means of establishing a relationship. Some states have very specific rules for the use of telehealth in prescribing while others are more vague or silent. Some of the rules center on whether telehealth is adequate to establish a patient-provider relationship which, again, varies across the states. This question of telehealth and prescribing has gained increasing attention in the last few years and will likely continue to be an area where states continue to develop their policies.



HIPAA/PRIVACY/SECURITY

The technology alone cannot make one HIPAA compliant. Human action is required in order to meet the necessary level of compliance that is required. HIPAA does not have specific requirements related to telehealth. Therefore, a telehealth provider must meet the same requirements of HIPAA as would be needed if the services were delivered in-person. However, to meet those requirements an entity may need to take different or additional steps that may not have been necessary if the service was delivered in-person.

Additionally, states may have their own privacy and security laws with which providers must be familiar. HIPAA is a baseline to protecting health information and some states may actually have a higher bar a provider must meet in order to be compliant. Additionally, states may have specific internet vendor laws that may not be directed at health services, but nonetheless impact them because they are services sold via the Internet. If a provider is offering services in another state, it would be prudent to look into the state laws covering these areas.

MALPRACTICE

There have been few cases that involve telehealth and many have revolved around teleradiology. The low number of cases, however, is likely due to the low adoption of telehealth. Additionally, there have been a few negligence cases that involve the non-use of telehealth. Telehealth malpractice cases are likely to increase the more it is widely used. However, one thing related to malpractice that providers should be aware of and which has become an issue to some providers is malpractice coverage. Not all carriers will provide malpractice coverage involving telehealth delivered services and not all coverage a provider has will be viable in another state. Additionally, some carriers will provide malpractice coverage, but may charge higher premiums. Very little policy has been related to address these issues. Providers should ensure that their malpractice insurance does cover telehealth delivered services and that it is viable in any other states they wish to practice in. A provider may find he or she will need to purchase additional insurance.

RESOURCES

Telehealth Resource Centers: www.telehealthresourcecenter.org
Center for Connected Health Policy: www.cchpca.org
Centers for Medicare and Medicaid: www.cms.gov/Medicare/Medicare-General-Information/Telehealth/

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A faster pathway to medical licensure

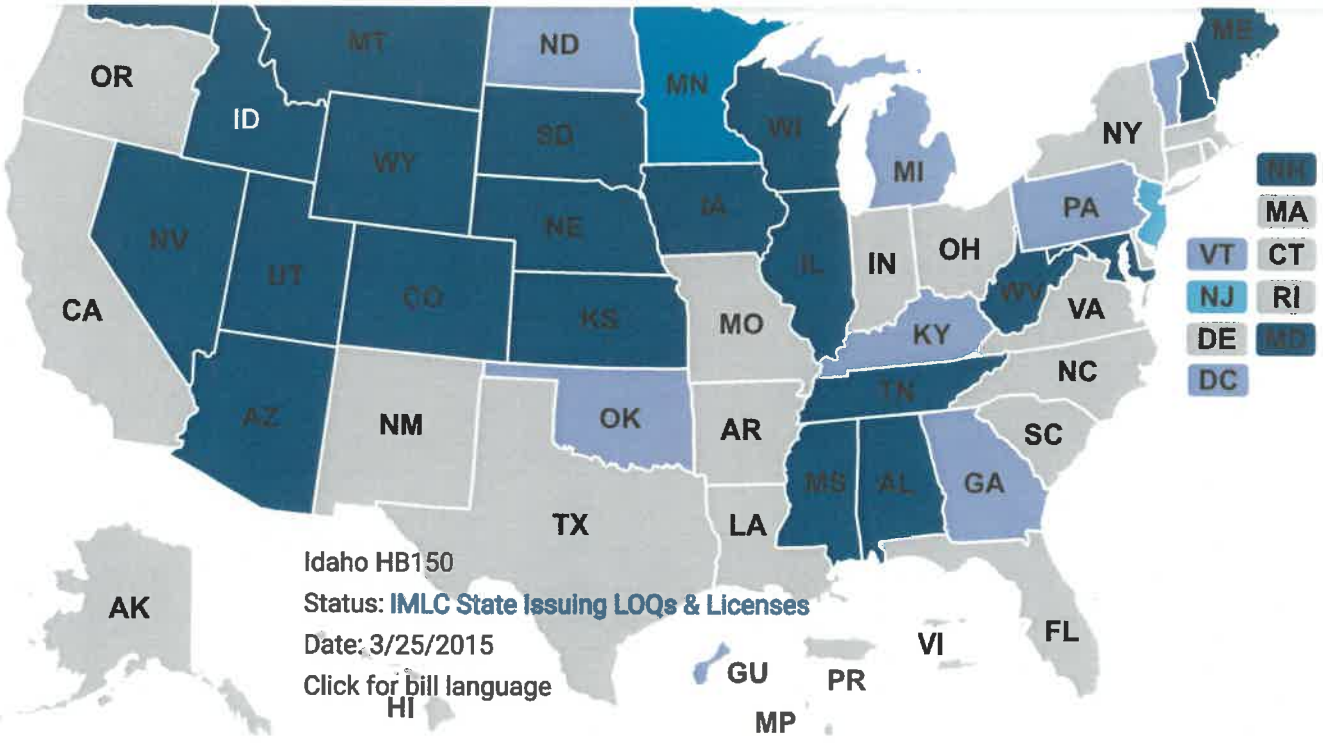
Do I qualify to use the Compact? Click here to find out.

The IMLC

The Interstate Medical Licensure Compact offers a new, voluntary expedited pathway to licensure for qualified physicians who wish to practice in multiple states. The IMLC mission is to increase access to health care for patients in underserved or rural areas and allowing them to more easily connect with medical experts through the use of telemedicine technologies. While making it easier for physicians to obtain licenses to practice in multiple states, the Compact strengthens public protection by enhancing the ability of states to share investigative and disciplinary information.

The IMLCC is an agreement between 29 states, the District of Columbia and the Territory of Guam, where physicians are licensed by 43 different Medical and Osteopathic Boards. Under this agreement licensed physicians can qualify to practice medicine across state lines within the Compact if they meet the agreed upon eligibility requirements. Approximately 80% of physicians meet the criteria for licensure through the IMLC.

The Application process is expedited by leveraging the physicians existing information previously submitted in their state of principal license (SPL). The SPL will verify the physicians information and conduct a fresh background check. Once qualified the Physician may select any number of Compact states for which they desire to practice.



= Compact Legislation Introduced

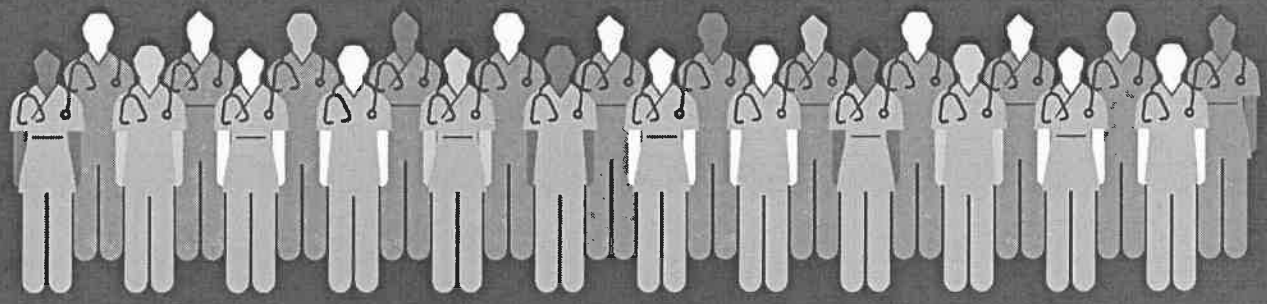
= IMLC Member State serving as SPL processing applications and issuing licenses*

= IMLC Member State non-SPL issuing licenses*

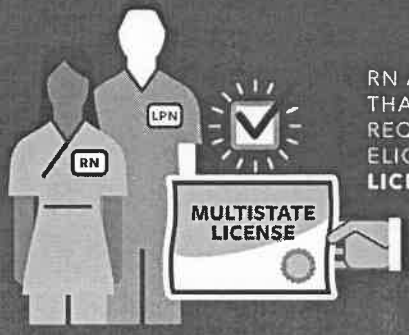
= IMLC Passed; Implementation In Process or Delayed*

* Questions regarding the current status and extent of these states' and boards' participation in the IMLC should be directed to the respective state boards.

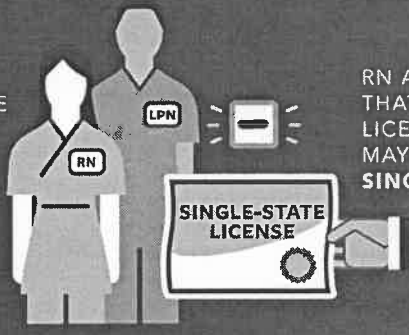
eNLC FAST FACTS



MORE THAN **2 MILLION NURSES** LIVE IN eNLC STATES AND HAVE THE OPPORTUNITY TO PRACTICE IN OTHER eNLC STATES



RN AND LPN/VN APPLICANTS THAT MEET UNIFORM LICENSURE REQUIREMENTS ARE ELIGIBLE FOR A **MULTISTATE LICENSE** IN eNLC STATES

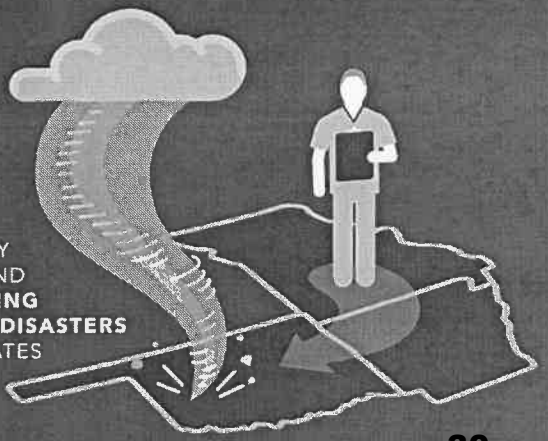


RN AND LPN/VN APPLICANTS THAT **DO NOT** MEET UNIFORM LICENSURE REQUIREMENTS MAY BE ELIGIBLE FOR A **SINGLE-STATE LICENSE**

NURSES IN eNLC STATES WITH **MULTISTATE LICENSES** ARE ABLE TO PRACTICE VIA TELENURSING IN ALL eNLC STATES

NURSE EDUCATORS IN eNLC STATES WITH **MULTISTATE LICENSES** ARE ABLE TO TEACH VIA DISTANCE EDUCATION IN ALL eNLC STATES

eNLC STATES ALLOW NURSES TO **EASILY PRACTICE ACROSS BORDERS** IN OTHER eNLC STATES



THE eNLC ALLOWS NURSES TO QUICKLY AND EASILY RESPOND TO **PROVIDE NURSING SERVICES DURING DISASTERS** IN OTHER eNLC STATES

PSYPACT AND DISCIPLINE:
Understanding the Role Each State Plays

One of the main purposes of PSYPACT is provide states with a regulatory mechanism designed to address disciplinary issues that occur across state lines in other compact states. PSYPACT specifies the role each state plays concerning disciplinary issues related to the practice of telepsychology and temporary in-person, face-to-face practice across state lines in PSYPACT states.

TELEPSYCHOLOGY

PSYPACT grants a psychologist the **AUTHORITY TO PRACTICE INTERJURISDICTIONAL TELEPSYCHOLOGY** into a:

RECEIVING STATE

- A psychologist must obtain an E.Passport Certification to practice telepsychology into a **RECEIVING STATE.**
- A psychologist is subject to the **RECEIVING STATE'S** scope of practice.
- A **RECEIVING STATE** can limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology.
- If a **RECEIVING STATE** takes action, it will notify the **HOME STATE** and the PSYPACT Commission.
- A **HOME STATE** will investigate and take appropriate action on reported inappropriate conduct in a **RECEIVING STATE** as it would if such conduct had occurred within the **HOME STATE**.
- A **HOME STATE'S** law will control in determining any adverse action against a psychologist's license.

If a psychologist's license in any **HOME STATE,** another **COMPACT STATE,** or any Authority to Practice Interjurisdictional Telepsychology in any **RECEIVING STATE**, is restricted, suspended or otherwise limited, the E.Passport will be revoked, and the psychologist will not be eligible to practice telepsychology in a **COMPACT STATE** under the Authority to Practice Interjurisdictional Telepsychology.

AND

HOME STATE

A psychologist must hold a current, full and unrestricted license to practice psychology in a **HOME STATE**, which has enacted PSYPACT.

A **HOME STATE** maintains authority over the license of any psychologist practicing under the authority of PSYPACT.

A **HOME STATE** can impose adverse action against a psychologist's license issued by the **HOME STATE.**

All **HOME STATE** disciplinary orders which impose adverse action are reported to the PSYPACT Commission.

TEMPORARY PRACTICE

PSYPACT grants a psychologist the **TEMPORARY AUTHORIZATION TO PRACTICE** in a:

DISTANT STATE

- A psychologist must obtain an Interjurisdictional Practice Certificate (IPC) to conduct temporary practice in a **DISTANT STATE.**
- A psychologist must practice within the scope of practice of the **DISTANT STATE** and is subject to the **DISTANT STATE'S** authority and law.
- A **DISTANT STATE** can limit, revoke or take adverse action on a psychologist's Temporary Authorization to Practice.
- If a **DISTANT STATE** takes action, it will notify the **HOME STATE** and the PSYPACT Commission.
- A **DISTANT STATE** will investigate and take appropriate action on reported inappropriate conduct which occurred in that **DISTANT STATE** as it would if such conduct had occurred within the **HOME STATE.**
- A **DISTANT STATE'S** law will control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

If a psychologist's license in any **HOME STATE**, another **COMPACT STATE**, or any Temporary Authorization to Practice in any **DISTANT STATE**, is restricted, suspended or otherwise limited, the IPC will be revoked, and the psychologist will not be eligible to practice in a **COMPACT STATE** under the Temporary Authorization to Practice.

FEDERATION OF STATE MEDICAL BOARDS

Telemedicine Policies

Board by Board Overview

Document Summary:

- Forty-nine (49) state boards, plus the medical boards of District of Columbia, Puerto Rico, and the Virgin Islands, require that physicians engaging in telemedicine are licensed in the state in which the patient is located.
- Fourteen (14) state boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine.
- Four (4) state boards require physicians to register if they wish to practice across state lines.
- Twenty-eight (28) states, plus the District of Columbia, require both private insurance companies and Medicaid to cover telemedicine services to the same extent as face-to-face consultations.
- Eighteen (18) states currently require only Medicaid to cover telemedicine services.
- One (1) state requires only private insurance companies to reimburse for services provided through telemedicine.

	State License Required	Reimbursement Parity	Other Rules/Regulations (citation only)
AL	√*[1]	Medicaid Only.	Ala. Admin. Code § 540-x-16
AK	√	Medicaid Only.	"Telehealth Statutes, Regulations & Policy" Alaska Dept. of Health and Social Services SB 74 of 2016, Chapter 25 SLA 16 "Board Issued Guidelines: Telemedicine" Alaska State Medical Board, Nov. 2014
AZ-M	√	Medicaid & Private.	Ariz. Rev. Stat. § 32-1421 "Issue Brief: Telemedicine" Arizona State Senate, Nov. 10, 2014
AZ-O	√	Medicaid & Private.	Ariz. Rev. Stat. § 32-1821 Ariz. Rev. Stat. § 32-1854 "Issue Brief: Telemedicine" Arizona State Senate, Nov. 10, 2014
AR	√	Medicaid & Private.	AR Code § 17-95-206 AR Stat. 10-3-1702(10) "When Does Telemedicine or Internet-Based Patient Healthcare Violate Regulation 2.8?" AR State Med. Board Newsletter Fall 2012

[1] √* denotes that a state may issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine.

CA-M	√	Medicaid & Private.	Ca. Business & Prof. Code § 2290.5 Medical Board of California
CA-O	√	Medicaid & Private.	Same as CA-M
CO	√	Medicaid & Private.	Colo. Rev. Stat. § 12-36-106(1)(g) "40-27: Guidelines for the Appropriate Use of Telehealth Technologies in the Practice of Medicine" Colorado Medical Board, Aug. 2015
CT	√	Medicaid & Private.	Public Act 15-88, Effective 10/1/15 CT Gen. Stat. § 17b-245c
DE	√	Medicaid & Private.	18 Del. C § 3370 24 Del. C § 1702 24 Del. C § 1769D
DC	√	Medicaid & Private.	DC Municipal Regulations § 4618
FL-M	√	Medicaid Only.	Fla. Stat. § 456.023 Fla. Admin. Code § 64B8-9.0141
FL-O	√	Medicaid Only.	Fla. Admin. Code § 64B15-14.0081
GA	√	Medicaid & Private.	Ga. Code § 360-3.07 O.C.G.A. § 43-34-31 Ga. Comp. R. & Regs. 360-3-.07
GU	#[2]	--	10 GCA § 12202(b)
HI	√	Medicaid & Private.	Haw. Rev. Stat. § 453-1.3
ID	√	--	Idaho Code Ann. § 54-5601
IL	√	Medicaid & Private.	225 ILCS 60/49.5
IN	√	Medicaid & Private. "IHCP to cover telehealth services by home health agencies" IHCP Bulletin, October 2014	Ind. Code 25-1-9.5 Ind. Code 25-22.5-14 Ind. Code 12-15-5-11 844 IAC 5-8
IA	√	Medicaid Only.	IAC 653 – 13.11
KS	√	Medicaid Only.	No unique laws regulating practice of telemedicine.

[2] Guam Code, 10 GCA § 12202(b), requires only that physicians are licensed somewhere within the United States.

KY	√	Medicaid & Private.	Ky. Rev. Stat. § 311.550(17) Ky. Rev. Stat. § 311.5975 "Policy: Telemedicine Statement" Kentucky Board of Medical Licensure, Sept. 1997 "Board Opinion regarding the use of Telemedicine Technologies in the Practice of Medicine" Kentucky Board of Medical Licensure, June 2014
LA	√*	Medicaid & Private.	La. Rev. Stat. § 37.1276.1 La. Rev. Stat. § 37:1271 La. Rev. Stat. § 40:1223.3 La. Admin. Code 46:XLV.408 "Advisory opinion: The use of telemedicine technologies with established patient" LA State Board of Medical Examiners, March 24, 2014
ME-M	√+	Medicaid & Private.	32 MRSA § 3300-D "Guidelines: Telemedicine" Maine Board of Licensure in Medicine, Sept. 2014 "Policy: Medical Practice Across State Lines" Northeast Region State Medical Boards, Sept. 1999 "Advisory Ruling: Telemedicine – Radiology" Maine Board of Licensure in Medicine, May 1994 "Advisory Ruling: Telemedicine – Psychotherapy" Maine Board of Licensure in Medicine, August 1993
ME-O	√	Medicaid & Private.	"Policy: Medical Practice Across State Lines" Northeast Region State Medical Boards, Sept. 1999
MD	√^[3]	Medicaid & Private.	Code of Maryland and Rules (COMAR) 10.32.05 "Telemedicine" MD Dept. of Health and Mental Hygiene

[3] √^ denotes that Maryland Revised Statutes § 14-302 exempts physicians licensed in adjoining states from being required to obtain a Maryland license.

MA	√	Private Only.	243 CMR 2.01(4)
MI-M	√	Medicaid & Private.	MCL 333.16283 et. seq.
MI-O	√	Medicaid & Private.	See MI-M
MN	√+4	Medicaid & Private.	Minn. Stat. § 147.032 "Telemedicine Registration" Minnesota Board of Medical Practice
MS	√	Medicaid & Private	MS Code Ann. § 73-25-34 MS Admin Code title 30, part 2635, ch. 5
MO	√	Medicaid & Private.	Mo. Rev. Stat. § 191.1145(6) Mo. Rev. Stat. § 191.1146 Mo. Rev. Stat. § 334.010 Mo. Rev. Stat. § 334.108
MT	√	Medicaid & Private.	MT Code Ann. § 37-3-102 MT Code Ann. § 37-3-343 Montana Admin. Code 24:156:8
NE	√	Medicaid Only.	Neb. Rev. Stat. § 71-8501 et seq.
NV-M	√*	Medicaid & Private.	NRS 630.261(e)
NV-O	√	Medicaid & Private.	NRS 633.165
NH	√	Medicaid & Private.	NH Rev. Stat. § 329:1-d NH Rev. Stat. § 415-J "Guidelines for Physician Internet and Prescribing" New Hampshire Board of Medicine Policy, April 2004 "Policy: Medical Practice Across State Lines" Northeast Region State Medical Boards, Sept. 1999
NJ	√*	--	NJ Rev. Stat §§ 45:9-21(b-c)
NM-M	√*	Medicaid & Private.	NM Admin. Code 16.10.2 et seq.
NM-O	√	Medicaid & Private.	No unique laws regulating practice of telemedicine.
NY	√	Medicaid & Private.	Telemedicine Statutes of New York "Statements on Telemedicine" NY State Office of Prof. Medical Conduct "Policy: Medical Practice Across State Lines" Northeast Region State Medical Boards, Sept. 1999
NC	√	Medicaid Only.	"Position Statement: Telemedicine" North Carolina Medical Board, November 2014
ND	√	Medicaid Only.	N.D. Cent. Code § 54-52.1-04.13 "Statement on Telemedicine Policy" ND Board of Medical Examiners, March 21, 2014
OH	√*	Medicaid Only.	OAC § 4731-10-11

[4] √+ denotes that a state requires physicians to register if they choose to practice medicine across state lines.

			OAC § 4731-11-01 OAC § 4731-11-09 ORC § 4731.296 "Position Statement on Telemedicine" State Medical Board of Ohio, May 2012
OK-M	√	Medicaid & Private.	Okla. Stat. § 36-6801 et seq. Oklahoma Admin. Code § 435 Amendments to OAC § 435, May 2016 "Adopted Telemedicine Policy (Mental Health)" Oklahoma Medical Board, Sept. 18, 2008 "Definition of Face to Face Encounter by Telemedicine in Oklahoma" Oklahoma Medical Board, Sept. 25, 2013
OK-O	√*	Medicaid & Private.	"Licensure" Okla. Stat. §59-633 "Guidelines on Telemedicine" Oklahoma State Board of Osteopathic Examiners
OR	√*	Medicaid & Private.	Or. Rev. Stat. § 677.139 Or. Rev. Stat. § 743A.058 Or. Admin. Code 410-130-0610 "Statement of Philosophy" Oregon Medical Board, January 2012
PA-M	√*	Medicaid Only.	Pa. Code § 17.4
PA-O	√*	Medicaid Only.	Pa. Code § 25.243
PR	√	--	20 LPRA § 6001 et seq.
RI	√	--	RI Gen Laws § 5-37-12 "Guidelines for Appropriate Use of Telemedicine and Internet in Medical Practice" Rhode Island Board of Medical Licensure and Discipline
SC	√	Medicaid Only.	S.C. Code Ann. 40-47-37 "Telemedicine Advisory Opinion" South Carolina Board of Medical Examiners, August 2015 "Establishment of Physician-Patient Relationship as Prerequisite to Prescribing Drugs" South Carolina Board of Medical Examiners, August 2015
SD	√	Medicaid Only.	SD Codified Laws § 36-4-41

			SD Codified Laws § 36-2-9
TN-M	√	Medicaid Only.	Tenn. Code Ann. § 63-1-155 Tenn. Code Ann. § 63-6-201 Tenn Comp. R. & Regs. 0880-02.16 "Policy Statement: Practicing Medicine on patients within Boundaries of Tennessee by Physicians in other states" Tennessee State Board of Medical Examiners, Oct. 1994
TN-O	√*	Medicaid Only.	Tenn. Comp. R. & Regs. 1050-02.17
TX	√*	Medicaid & Private.	22 Tex Admin. Code § 174 "Out-of-State Telemedicine License" Texas Medical Board
UT-M	√	Medicaid Only.	Utah Code § 58-1-307
UT-O	√	Medicaid Only.	Same as UT-M
VT-M	√	Medicaid & Private.	"Policy: Medical Practice Across State Lines" Northeast Region State Medical Boards, Sept. 1999
VT-O	√	Medicaid & Private.	Same as VT-M
VI	√	--	VI St. T. 27 § 16
VA	√	Medicaid & Private.	Va. Code § 38.2-3418.16 "Guidance Document 85-21" Virginia Board of Medicine, Feb. 2015
WA-M	√	Medicaid Only.	RCW 18.71.030 WAC 182-531-1730 "Guideline: Appropriate Use of Telemedicine" Medical Quality Assurance Commission, Oct. 2014
WA-O	√	Medicaid Only.	RCW 18.57.040
WV-M	√	Medicaid Only.	W Va. Code § 30-3-13 "Position Statement on Telemedicine" West Virginia Board of Medicine, Nov. 2014
WV-O	√	Medicaid Only.	"Telemedicine Policy" West Virginia Board of Osteopathic Medicine, Sept. 2015
WI	√	Medicaid Only.	Wisconsin Admin. Code Med. § 24
WY	√	Medicaid Only.	WY Board Rules § 1.4(e)

For informational purposes only: This document is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative.

Non-cited laws, regulation, and/or policy could impact analysis on a case-by-case or state-by-state basis. All information should be verified independently.

Kentucky Telehealth Act – SB112 Fact Sheet

SB112 Telehealth Act, effective **July 1, 2019**, redefines telehealth, widens the scope of payment parity, and includes the home to be an originating site. It applies to fully-insured Kentucky Medicaid, Medicaid managed organizations, health benefit plans, and self-insured plans.

Amends 304.17A-005 to redefine "telehealth":

- *"The delivery of healthcare-related services by a health care provider who is licensed in Kentucky to a patient or client through a face-to-face encounter with access to real-time interactive audio and video technology or **store-and-forward** services that are provided via asynchronous technologies as the standard practice of care where images are sent to a specialist for evaluation."*
    - **Inclusion of store-and-forward** as a new addition
- *"The requirement for a face-to-face encounter shall be satisfied with the use of **asynchronous telecommunications technologies** in which the health care provider has access to the patient's or client's medical history prior to the telehealth encounter."*
    - Asynchronous options include remote patient monitoring (RPM) and store-and-forward only
    - Delivery via a secure communications connection is required

Section 5. KRS 304.17A-138 is amended as follows:

- *"A health benefit plan shall reimburse for covered services provided to an insured person through telehealth as defined in Section 4 of this Act. Telehealth coverage and reimbursement shall be equivalent to the coverage for the same service provided in person unless the telehealth provider and the health benefit plan contractually agree to a lower reimbursement rate for telehealth services."*
    - Expanding telehealth coverage and payment parity across services
- Telehealth coverage and reimbursement will receive coverage equivalent for services provided in-person unless the telehealth provider and the health benefit plan agree to a lower reimbursement rate for telehealth service
    - Complete **telehealth and payment parity**
    - Eliminates the restriction requiring the provider to be in the same physical location as the patient – **allowing the home to be an originating site**
    - Eliminates any prior authorizations, reviews, or clearances normally not required for equivalent in-person services
- Specifies health benefit plans shall not be required to provide coverage for services that are not medically necessary

Source: Visuwell 5/22/2019

mhcc.maryland.gov

Telemedicine

Detailed below is information compiled by the Maryland Health Care Commission (MHCC) regarding factors impacting the adoption of telehealth in Maryland.

Telehealth uses medical information shared through two-way audio/video and other forms of telecommunication technologies, including mobile communication devices and remote monitoring devices, to improve patients' health status.[1] [2]. There are many benefits to providing telehealth services. Telehealth has the potential to reduce health care costs by enabling more timely interventions in care delivery, reducing overhead costs associated with office visits, and allowing for consultations without the need for a separate appointment with a specialty provider[3]. There are several barriers that may impact the adoption of telehealth.

Physician licensing

Regulations governing the provision of telehealth services vary by state. In Maryland, a physician must be licensed in the State if either or both the individual practicing medicine or if the patient is physically located in Maryland[4]. In other states, the physician can pay a fee to practice across state lines. The lack of standardized telehealth licensing requirements impacts providers' willingness to offer telehealth services.[5]

Credentialing

The credentialing process for telehealth services can be complicated and costly. If a multi-site hospital credentials physicians specifically for the site at which they are located, then every physician within the hospital system would need to be credentialed at all hospital sites in order to provide telehealth services. This requires more time to complete credentialing paperwork and a high cost for administrative processing, which can be difficult for hospitals and health care practices to initiate.[6] [7]

Liability

There are inconsistent guidelines among carriers offering liability and malpractice insurance for telehealth services. Each carrier defines their own standards/criteria that must be met to receive coverage of telehealth services[8]. A physician must work with their insurance carrier to determine if telehealth coverage is available and if so, the extent of coverage allowed under their policy.

Financial

When telehealth services are being provided from a physician to a patient at their home, the financial benefits are clear with respect to reduced travel time for the physician and patient and reduced overhead by elimination of the office setting[9]. However, the financial benefits for providing telehealth services are much less clear when looking at a reduction in utilization of higher cost medical care, such as emergency department visits and inpatient hospital stays. This makes justification for the up-front costs

associated with purchasing and maintaining equipment difficult from an economic benefits perspective[10].

Technology

Providing care via telehealth may require a provider to access a patient's electronic health information remotely and from a variety of sources. Some technologies used to provide telehealth are limited in their ability to exchange health information electronically. This can result in silos that make it difficult for providers to gain access to medical data necessary to make informed decisions regarding a patient's health care, including during a telehealth encounter[11]. In addition, lack of broadband access in some areas can impede on the ability to deliver telehealth services, such as video streaming and storage and transmission of vital health information. Additionally, the integration and connectivity of health information required to provide telehealth services requires defined standards for data confidentiality and integrity when providing telehealth services[12].

Organizational Structure

Traditionally, health care organizational processes are set up to support face-to-face encounters. Telehealth services can be viewed as an ancillary or secondary service and not integrated into the standard of care. In addition, an organization must have the staff to support telehealth delivery. Access to providers that are able and willing to provide telehealth services and support the needs of the organization as they implement and grow their telehealth services is a necessary resource for organizations looking to provide telehealth services.[13]

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1. Maryland Telemedicine Task Force Final Report, October 2014
2. American Telemedicine Association. Telehealth Basics
3. American Telemedicine Association. Telehealth Basics
4. COMAR 10.32.05.03
5. eVisit: Barriers to Telemedicine and How to Solve Them.
6. eVisit: Barriers to Telemedicine and How to Solve Them.
7. LeRouge, Cynthia and Garfield, Monica J. Crossing the Telemedicine Chasm: Have the U.S. Barriers to Widespread Adoption of Telemedicine Been Significantly Reduced? Int. J. Environ. Res. Public Health 2013, 10, 6472-6484; doi:10.3390/ijerph10126472.
8. LeRouge, Cynthia and Garfield, Monica J. Crossing the Telemedicine Chasm: Have the U.S. Barriers to Widespread Adoption of Telemedicine Been Significantly Reduced? Int. J. Environ. Res. Public Health 2013, 10, 6472-6484; doi:10.3390/ijerph10126472.
9. LeRouge, Cynthia and Garfield, Monica J. Crossing the Telemedicine Chasm: Have the U.S. Barriers to Widespread Adoption of Telemedicine Been Significantly Reduced? Int. J. Environ. Res. Public Health 2013, 10, 6472-6484; doi:10.3390/ijerph10126472.
10. LeRouge, Cynthia and Garfield, Monica J. Crossing the Telemedicine Chasm: Have the U.S. Barriers to Widespread Adoption of Telemedicine Been Significantly Reduced? Int. J. Environ. Res. Public Health 2013, 10, 6472-6484; doi:10.3390/ijerph10126472.
11. MHealth News: The top three barriers to telehealth adoption
12. LeRouge, Cynthia and Garfield, Monica J. Crossing the Telemedicine Chasm: Have the U.S. Barriers to Widespread Adoption of Telemedicine Been Significantly Reduced? Int. J. Environ. Res. Public Health 2013, 10, 6472-6484; doi:10.3390/ijerph10126472.
13. LeRouge, Cynthia and Garfield, Monica J. Crossing the Telemedicine Chasm: Have the U.S. Barriers to Widespread Adoption of Telemedicine Been Significantly Reduced? Int. J. Environ. Res. Public Health 2013, 10, 6472-6484; doi:10.3390/ijerph10126472.

Last Updated: 5/1/2019

Maryland Administrative Regulations 10.32.05.03

Except as specified in Health Occupations Article, §14-302, Annotated Code of Maryland, an individual shall be a licensed Maryland physician in order to practice telemedicine if one or both of the following occurs:

A. The individual practicing telemedicine is physically located in Maryland;

B. The patient is in Maryland.

§ 14-302. Exceptions from licensing -- In general

(4) A physician who resides in and is authorized to practice medicine by any state adjoining this State and whose practice extends into this State, if:

(i) The physician does not have an office or other regularly appointed place in this State to meet patients; and

(ii) The same privileges are extended to licensed physicians of this State by the adjoining state;

NORTH CAROLINA MEDICAL BOARD

Resources & Information

Position Statements

Telemedicine

Categories: Clinical Practice, Prescribing Adopted Jul 2010 | Amended Mar 2019

"Telemedicine" is the practice of medicine using electronic communication, information technology, or other means between a licensee in one location and a patient in another location with or without an intervening health care provider. The term telemedicine incorporates the practices of telehealth.

The Board recognizes that technological advances have made it possible for licensees to provide medical care to patients who are separated by some geographical distance. As a result, telemedicine is a useful practice model that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and the potential of reduced healthcare costs, increased efficiency, and improved overall healthcare outcomes. The call for ongoing research and formal training in the care models and technologies associated with telemedicine reflects the evolving nature of telemedicine practice.

The Board cautions, however, that licensees providing care to North Carolina patients via telemedicine will be held to the same established standard of care as those practicing in traditional in-person medical settings. The Board does not endorse a separate standard of care for telemedicine. Licensees, who fail to conform to the North Carolina statewide standard of care, may be subject to discipline by this Board.

The Board provides the following considerations to its licensees as guidance in providing medical services via telemedicine:

Training of Staff

Staff involved in the telemedicine visit should be trained in the use of the technology being used to deliver care and competent in its operation.

Evaluations and Examinations

Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide, or rely upon, an appropriate evaluation prior to diagnosing and/or treating the

patient. This evaluation need not be in-person if the licensee employs technology sufficient to accurately diagnose and treat the patient in conformity with the applicable standard of care. A diagnosis should be established using accepted medical practices, i.e., a patient history, mental status evaluation, physical examination, and appropriate diagnostic and laboratory testing.

Evaluations may also be considered appropriate if a licensed health care professional is able to facilitate aspects of the patient assessment needed to render reasonable diagnostic possibilities and care plans. On the other hand, a simple questionnaire without an appropriate evaluation may be a violation of law and/or subject the licensee to discipline by the Board.

Licensee-Patient Relationship

The Board stresses the importance of proper patient identification prior to any telemedicine encounter. Failure to verify the patient's identity may lead to fraudulent activity or the improper disclosure of confidential patient information. The licensee using telemedicine should verify the identity and location of the patient. Furthermore, the licensee's name, location, and professional credentials should be provided to the patient. Licensees using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers.

Prescribing

Licensees are expected to practice in accordance with the Board's Position Statement "Contact with Patients Before Prescribing." It is the position of the Board that it is not consistent with the current standard of care to prescribe controlled substances for the treatment of pain in which the only patient encounter is by means of telemedicine and there are no other licensed healthcare providers involved in the initial and ongoing evaluations of the patient. Licensees prescribing controlled substances by means of telemedicine for other conditions should comply with all relevant federal and state laws and are expected to participate in the Controlled Substances Reporting System.

Medical Records

The licensee treating a patient via telemedicine must maintain a complete record of the telemedicine patient's care consistent with the prevailing medical record standards. The medical record should clearly document all aspects of care including email, text, photos, phone contact, and other forms of communication. HIPAA and related privacy and security documents should be present and signed where appropriate. Appropriate informed consent documents acknowledging the risks, limitations, alternatives, and benefits of the telemedicine encounter should be included.

The licensee must maintain the medical record's confidentiality and provide a copy of the medical record to the patient in a manner consistent with state and federal law. If the patient has a primary care provider and a telemedicine provider for the same ailment, then the primary care provider's medical record and the telemedicine provider's medical record constitute one complete patient record. Licensees practicing via telemedicine will be held to the same standards of professionalism

concerning the transfer of medical records and communications with the patient's primary care provider and medical home as those licensees practicing via traditional means.

Disclaimers

Practitioners of telemedicine should consider providing a statement identifying any unique limitations of the electronic model by which care is being provided. Such patient notification can be distributed prior to providing services and included in all direct advertising to the public.

Licensure

The Board deems the practice of medicine to occur in the state where the patient is located. Therefore, any licensee using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina. Licensees need not reside in North Carolina if they have a valid, current North Carolina license.

North Carolina licensees intending to practice medicine via telemedicine technology to treat or diagnose patients outside of North Carolina should check with other state licensing boards. Most states require physicians to be licensed, and some have enacted limitations on telemedicine practice or require or offer a special registration. A directory of all U.S. medical boards may be accessed at the Federation of State Medical Boards web site: http://www.fsmb.org/directory_smb.html.

Physical Address: 1203 Front Street, Raleigh, NC, 27609-7533
Mailing Address: PO Box 20007, Raleigh, NC, 27619-0007
Telephone: (919) 326-1100 or (919) 326-1109 | Free Long Distance: (800) 253-9653
General Fax: (919) 326-0036 | Licensing Dept. Fax: (919) 326-1130

tnmed.org

New Telemedicine Rules from the Board of Medical Examiners

New Telemedicine Rules from the Board of Medical Examiners

September 27, 2016

Our society now uses electronic devices almost constantly and the practice of telemedicine is becoming more prevalent as technological capabilities have improved. The increased reliance on technology and public demands for access to medical services via technology prompted the Tennessee Board of Medical Examiners (BME) to begin a review of the licensure requirements for telemedicine in 2014. During the rule-making process, the TMA legal department monitored the meetings and provided comments and testimony regarding each iteration of the rule. The BME recently published its final telemedicine rules and they are effective on October 31, 2016. Below is a summary and you may access the entire rule here. The Board of Osteopathic Medicine has not promulgated any changes to its rules related to telemedicine.

Telemedicine Licensure
Unless an exemption applies, a physician practicing medicine on a patient located in Tennessee must be licensed to practice medicine in Tennessee. Beginning on October 31, the BME will no longer issue new telemedicine licenses. Physicians who currently hold this type of license will be able to either renew their telemedicine license or transfer it to a full medical license, if they are board certified and otherwise meet the qualifications specified in the rule. Going forward, any physician who provides or delivers a medical service in Tennessee, including telemedicine, must apply for and receive, a full medical license unless he/she is eligible for an exemption from licensure.

Telemedicine and Physician-Patient Relationship Defined
"Telemedicine" is defined as the practice of medicine using electronic communication, information technology or other means, between a licensee in one location and a patient in another location. It typically involves the application of secure video conferencing or store-and-forward technology to provide or support healthcare delivery by replicating the interaction of an in-person encounter between a physician and a patient. Audio-only telephone conversations, emails/instant messaging conversations or faxes, even between a physician and patient, are not considered telemedicine.

The telemedicine rules define "store-and-forward technology" as the use of asynchronous electronic communications between a patient and healthcare services provider at a distant site for the purpose of diagnostic and therapeutic assistance in the care of patients and includes the transferring of medical data from one site to another through the use of a device that records or stores images that are sent or forwarded via telecommunication to another site for consultation.

The amended rule is the first time "physician-patient relationship" is defined in state rules. Previously, it was only defined in Tennessee court decisions. The rules state that a physician-patient relationship exists when a physician serves a patient's medical needs whether or not there has been an encounter in person between the physician and patient. An encounter is the rendering of a documented medical opinion concerning evaluation, diagnosis, and/or treatment of a patient, whether the physician is physically present in the same room, in a remote location within the state, or across state lines. For a detailed discussion of what constitutes a physician-patient relationship, see TMA's online Law Guide topic titled *Physician-Patient Relationship*.

Telemedicine Requirements

A physician practices telemedicine in this state when the patient encounter that establishes or maintains the physician-patient relationship occurs with the patient located in a remote site and certain conditions are met. These conditions depend on whether a facilitator is present. "Facilitator" is defined as an individual, often affiliated with a local system of care, or a parent or legal guardian of the patient.

1. If no facilitator is present with the patient –
    1. The patient must utilize adequately sophisticated technology to enable the remote physician to verify the patient's identity and location with an appropriate level of confidence; and
    2. The patient must transmit all relevant health information at the level of store-and forward technology or secure video conferencing; and
    3. The physician must disclose his or her name, current and primary practice location, medical degree, and recognized specialty area, if any, and in accordance with the title identification law found at T.C.A. § 63-1-109. See TMA's online Law Guide topic, *Title Identification – Communicating Credentials to Patients* for more information on the requirements of the title identification law.
    4. A minor patient may not be treated without a facilitator present, unless the law allows the minor to consent to the treatment. The facilitator must be physically present with the patient and is responsible for verifying the identity and location of the patient and for the origination, collection, and transmission of data in the form of images or clinical data to the physician performing the evaluation remotely. For additional information, see TMA's *Treatment of Minors Guide* for the instances when a minor may consent to treatment without parental consent.
2. If a facilitator is present with the patient –
    1. The facilitator must personally verify the identity of the patient. All relevant health information must be transmitted to the remote physician using, at a minimum, means to transmit that is considered store-and-forward technology. The facilitator and the patient may interact with the physician at the remote location via secure video conferencing or store-and-forward; and
    2. The facilitator must identify himself or herself, role, and title to the patient and the remote physician; and
    3. The remote physician must disclose his or her name, current and primary practice location, medical degree and recognized specialty area, if any, and in accordance with the title identification law found at T.C.A. § 63-1-109. See our Law Guide

topic, *Title Identification – Communicating Credentials to Patients* for more information on the requirements of this law.

Medical Record and Documentation
A physician must have appropriate patient medical records or be able to obtain information during the telemedicine encounter adequate to treat the patient. All pertinent data and information from any telemedicine encounter and the technology used must be entered into the medical record.

Telemedicine Exemptions from Licensure
If any of the following situations are present, the physician is not considered to be practicing telemedicine, so no Tennessee license is required:

1. A physician, when requested to do so by another physician licensed by the BME, engages in medical interpretation and renders an opinion based on date transmitted electronically. In this situation, the physician providing the interpretation need not examine the patient and need not have the complete medical record accessible, unless the interpreting physician believes that additional information is necessary. The opinion from the interpreting physician must be reduced to writing, which include the name and electronic signature of the interpreting physician. The performance of a medical interpretation by a physician is the rendering of a diagnosis regarding a particular patient by examination of radiologic imaging studies, or tissue specimens, bodily fluid specimens (including but not limited to urine, blood and cerebrospinal fluid) or medical records requested by another physician or licensed health care provider
2. Licensed/registered physicians or surgeons of other states when called in consultation regarding specific clinical or scientific aspects of the field of medicine by a Tennessee licensed/registered physician as provided by T.C.A. §63-6-204 (a)(3);[1]
3. US Military physicians operating within the Federal jurisdiction and regulations related to their duties as provided by T.C.A. §63-6-204 (a)(3);
4. The informal practice of medicine between physicians in the form of uncompensated professional dialogue regarding aspects of the field of medicine.
5. A recognized highly specialized licensed physician from another state or country who specializes in the diagnosis and/or treatment of rare or orphan diseases and who provides consultation to research hospitals with or without compensation or the expectation of compensation.

Please direct any questions to the Legal Department at legal@tnmed.org or 800-659-1862, extension 1645.

[1] (3) This chapter shall not apply to surgeons of the United States army, navy, air force or marine hospital service, or to any registered physician or surgeon of other states when called in consultation by a registered physician of this state, or to midwives, veterinary surgeons, osteopathic physicians or chiropractors not giving or using medicine in their practice or to opticians, optometrists, chiropodists or Christian Scientists.

§3300-D. Interstate practice of telemedicine

1. Definition. For the purposes of this section, "telemedicine" has the same meaning as in Title 24-A, section 4316, subsection 1.

2. Requirements. A physician not licensed to practice medicine in this State may provide consultative services through interstate telemedicine to a patient located in this State if the physician is registered in accordance with subsection 3. A physician intending to provide consultative services in this State through interstate telemedicine shall provide any information requested by the board and complete information on:

A. All states and jurisdictions in which the physician is currently licensed;

B. All states and jurisdictions in which the physician was previously licensed; and

C. All negative licensing actions taken previously against the physician in any state or jurisdiction.

3. Registration. The board may register a physician to practice medicine in this State through interstate telemedicine if the following conditions are met:

A. The physician is fully licensed without restriction to practice medicine in the state from which the physician provides telemedicine services;

B. The physician has not had a license to practice medicine revoked or restricted in any state or jurisdiction;

C. The physician does not open an office in this State, does not meet with patients in this State, does not receive calls in this State from patients and agrees to provide only consultative services as requested by a physician, advanced practice registered nurse or physician assistant licensed in this State and the physician, advanced practice registered nurse or physician assistant licensed in this State retains ultimate authority over the diagnosis, care and treatment of the patient;[2015, c.

D. The physician registers with the board every 2 years, on a form provided by the board; and

E. The physician pays a registration fee not to exceed $500.

4. Notification of restrictions. A physician registered to provide interstate telemedicine services under this section shall immediately notify the board of restrictions placed on the physician's license to practice medicine in any state or jurisdiction.

5. Jurisdiction. In registering to provide interstate telemedicine services to residents of this State under this section, a physician agrees to be subject to the laws and judicial system of this State and board rules with respect to providing medical services to residents of this State.

6. Notification to other states. The board shall obtain confirmation of licensure from all states and jurisdictions in which a physician applying for registration has ever been licensed prior to registering the physician pursuant to subsection 3. The board shall request notification from a state or jurisdiction if future adverse action is taken against the physician's license in that state or jurisdiction.

New Mexico

INSTRUCTIONS FOR COMPLETING THE LICENSE APPLICATION FOR TELEMEDICINE LICENSE

Definition: The practice of medicine across state lines as defined in the Medical Practice act, Sections 61-6-6, K NMSA 1978. A telemedicine license is a limited license that allows a physician located outside New Mexico to practice medicine on patients located in New Mexico.

Requirements: Each applicant for a Telemedicine license must be of good moral character and hold a full and unrestricted license to practice medicine in another state or territory of the United States.

Instructions:

Step 1: Complete the NM Statewide Application in its entirety. Please type or print legibly in blue or black ink. An incomplete application will delay processing.

Step 2: The following documentation and fee must be included with the application: a. Application fee of $400 made payable to the New Mexico Medical Board. b. Completed form entitled "Applicant's Oath" including attaching a passport-quality color photo of the applicant taken within the last six months. c. Copy of your Specialty Board Certificate and re-certification, if applicable.

Step 3: Attach your payment to the Board to the front of the application. Applications will not be processed until the application fee has been received. The application fee is payable in U.S. funds by cashier's check, money order, personal check, Visa, or MasterCard. All fees are non-refundable. Mail your application and fee to: New Mexico Medical Board 2055 S. Pacheco Street, Building 400 Santa Fe, New Mexico 87505

Step 4: The following documentation must be requested by the applicant and submitted directly from the source to the Board. WE WILL NOT ACCEPT THESE DOCUMENTS FROM THE APPLICANT. a. Verification of Licensure: You must have each and every state or territorial licensing authority which ever issued you a license to practice medicine (including temporary licenses and education/training permit, whether active or inactive) verify the standing of that license to the Board. We recommend you use VeriDoc at www.veridoc.org to request license verifications to be sent directly to the NM Medical Board.

Licensure Process: Upon receipt of a completed application, including all required documentation and fee, Board staff will request and review an AMA Physician Profile and Federation of State Medical Boards Board Action Databank Search. When the application is complete in every detail, it will be reviewed for quality assurance and then forwarded to the Board designee for review and possible approval for licensure. A personal interview is not required unless there is a discrepancy in the application that cannot be resolved. Initial License Expiration: Telemedicine licenses expire on July 1 following the date of issue. Initial licenses are valid for a period of not more than 13 months and not less than one (1) month.

§ 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time, and submit to the U.S. Secretary of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

26. A provision for the payment of medical assistance for medically necessary health care services provided through telemedicine services.

7/24/2019

Code of Virginia
Title 38.2. Insurance
Chapter 34. Provisions Relating to Accident and Sickness Insurance

§ 38.2-3418.16. Coverage for telemedicine services.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

B. As used in this section:

"Remote patient monitoring services" means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

"Telemedicine services" as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

C. An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

D. An insurer, corporation, or health maintenance organization shall not be required to reimburse the treating provider or the consulting provider for technical fees or costs for the provision of telemedicine services; however, such insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through face-to-face consultation or contact.

E. Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require pre-authorization of emergent telemedicine services.

F. An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through face-to-face diagnosis, consultation, or treatment.

G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

H. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2011, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

I. This section shall not apply to short-term travel, accident-only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

J. The coverage required by this section shall include the use of telemedicine technologies as it pertains to medically necessary remote patient monitoring services to the full extent that these services are available.

2010, c. 222; 2014, c. 814; 2015, cc. 32, 115; 2019, cc. 211, 219.

NATIONAL CONSORTIUM OF
TELEHEALTH
RESOURCE CENTERS

Telehealth Reimbursement

www.telehealthresourcecenter.org
February 2019

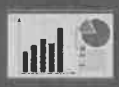
Reimbursement for telehealth is unfortunately complicated, and the policy environment is in constant flux. In addition to self-pay, Medicare, Medicaid and many private payers offer some form of reimbursement for telehealth delivered services. However, policies vary by both state and payer.

THE BIG PICTURE

The following factors may all play a role when determining whether a service can be reimbursed if delivered using telehealth technologies:

Who is the third-party payer?
- ✓ Medicare
- ✓ Medicaid
- ✓ Private Payer

Who is the direct recipient of the telehealth encounter?
- ✓ The patient
- ✓ Another clinician (E-Consult, Project ECHO)



What modality of telehealth is being used?
- ✓ Synchronous or "live" video
- ✓ Asynchronous or "store and forward"
- ✓ Remote monitoring
- ✓ Mobile health or "mhealth"

Where is the patient located, otherwise known as the "originating site"?
- ✓ Geographic Location
- ✓ Type of Facility
  - Health care facility (hospital, FQHC, private practice)
  - Non-health care facility (school, worksite, kiosk, home)

What type of service is being provided and how is that service being coded for billing purposes?

What type of health care provider is delivering the service? (e.g., Medical Doctor, Nurse Practitioner, Psychologist, Allied Health Professional, Health Educator, EMT)

MEDICAID AND PRIVATE PAYERS

CMS gives states the ability to determine their own Medicaid policies related to telehealth which results in different policies across all 50 states and the District of Columbia. Policies may contain limitations such as the ones found in Medicare or additional requirements such as obtaining informed consent. Private payer policies may be dictated by state laws and also may vary greatly from payer to payer. While some private payer laws mandate coverage of services delivered via telehealth, they may not necessarily mandate that the reimbursement rate be equal to what it would be had the service been provided in person. Each Medicaid program and private payer law has its own caveats, requirements and restrictions associated with the various modalities of telehealth. Additionally, policies and laws change frequently. The Center for Connected Health Policy (CCHP) maintains a 50 State Telehealth Laws and Reimbursement database that is searchable by jurisdiction, rule type (laws, regulations, Medicaid Program) and topic. The database also tracks recent and pending legislative activity.

Visit http://www.cchpca.org/ to get more detailed information about each state's Medicaid policies and private payer laws.

MEDICARE

Reimbursement for telehealth delivered services is only made if certain requirements are met. When billing, the 02 place of service (POS) code must be used to indicate the service took place via telehealth, except the GT modifier allowed on institutional claims by Critical Access Hospital Method II. The GQ modifier should be used for indicating a service took place via asynchronous/store-and-forward in a demonstration program in Alaska or Hawaii. To determine if a service qualifies for reimbursement under Medicare, the following must be met:

Type of Service

Medicare will only reimburse for a specific set of CPT/HCPCS code. Each year, Medicare may approve additional codes to be reimbursed. Medicare will only reimburse for live video. The only exception is when the service is provided by a federal demonstration project in Hawaii or Alaska, in which case, they will also reimburse for store-and-forward.

Geographic and Originating Site:

In order to be reimbursed for live-video telehealth, the patient must be located in a non-Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HPSA). The Health Resources Services Administration (HRSA) maintains a Medicare telehealth payment eligibility search tool (http://datawarehouse.hrsa.gov/tools/analyzers/geo/Telehealth.aspx) to determine if the specific location of an originating site qualifies. Additionally, Medicare limits the originating sites eligible to receive services through telehealth to the following facilities:

- ✔ Provider offices
- ✔ Hospitals
- ✔ Critical access hospitals
- ✔ Rural health clinics
- ✔ Federally qualified health centers
- ✔ Skilled nursing facilities
- ✔ Community mental health centers
- ✔ Hospital-based or critical access hospital-based renal dialysis centers

In January 2019, CMS finalized regulations to reimburse for End-Stage Renal Disease (ESRD) services when delivered via telehealth to a patient's home or a renal dialysis facility and for acute stroke treatment when delivered via telehealth to a mobile stroke unit or any other eligible originating site. Additionally, CMS provides exemption from the geographic requirement to ESRD services delivered to the home, renal dialysis facilities, and hospital-based or critical access hospital-based renal dialysis centers. Mobile stroke units and all currently eligible originating sites are exempt from the geographic restrictions for acute stroke treatment services.

Beginning July 1, 2019, the originating site geographic requirements will be removed for any existing Medicare telehealth originating site for the purposes of treating individuals with substance use disorders or co-occurring mental health disorders. The home will be an eligible originating site for these services, however it will not qualify for the facility fee.

Provider Restriction:

Only the following list of distant site providers qualify to deliver services and receive reimbursement via telehealth through Medicare:

- ✔ Physicians
- ✔ Nurse practitioners
- ✔ Physician assistants
- ✔ Nurse midwives
- ✔ Clinical nurse specialists
- ✔ Clinical psychologists and clinical social workers
- ✔ Registered dietitians or nutrition professionals

Chronic Care Management and Remote Monitoring:

CMS reimburses for chronic care management codes, which provides for non-face-to-face consultation and could include remote monitoring activities. Additionally, in the final calendar year 2018 Physician Fee Schedule, CMS unbundled code 99091 allowing providers to get reimbursed separately for time spent on collection and interpretation of health data generated remotely. Finally, in January 2019, CMS added reimbursement for 3 additional codes for remote physiological monitoring to align with new codes created by the CPT Editorial Panel.

Payment for Remote Communication Technology:

In January, 2019, CMS began reimbursement for certain kinds of services furnished remotely using communications technology that are not considered "Medicare telehealth services." Because these services are not defined as telehealth, they are not subject to the limitations and restrictions previously outlined for telehealth services.

Services:

Remote communication technology services include the following:

- Brief communication technology-based service (or "virtual check-in"): A brief, non-face-to-face check-in with an established patient via communication technology to assess whether or not an office visit or other service is necessary. This service is only available to practitioners who furnish E/M services, and could take place via live video or telephone call.

- Remote evaluation of pre-recorded patient information: Remote professional evaluation of patient-transmitted information conducted via pre-recorded video or image technology to determine whether or not an office visit or other service is necessary. This would only be available for established patients.

- Interprofessional internet consultation: Interprofessional internet consultations between professionals performed via communications technology. This service is limited to practitioners that can independently bill Medicare for E/M visits. This could take the form of either a telephone call or a live or synchronous internet consultation.

NOTE: Federally qualified health centers may provide both the Virtual Check-In and the Remote Evaluation of pre-recorded patient information. However, they are not able to use the interprofessional internet consultation codes.

The National Consortium of Telehealth Resource Centers (NCTRC) is an affiliation of the 14 Telehealth Resource Centers funded individually through cooperative agreements from the Health Resources & Services Administration, Office for the Advancement of Telehealth. The goal of the NCTRC is to increase the consistency, efficiency, and impact of federally funded telehealth technical assistance services. This Reimbursement Fact Sheet was made possible by 14 Telehealth Resource Centers and administered through grant #G22RH30365 from the Office for the Advancement of Telehealth, Federal Office of Rural Health Policy, Health Resources and Services Administration, Department of Health and Human Services.
For more information, contact your Telehealth Resource Center at www.telehteahresourcecenter.org

TELEHEALTH SERVICES

Target Audience: Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

TABLE OF CONTENTS

Learn about these Medicare telehealth services topics:

- Originating sites
- Distant site practitioners
- Telehealth services
- Telehealth services billing and payment
- Telehealth originating sites billing and payment
- Resources
- Helpful websites and Regional Office Rural Health Coordinators

Medicare pays for specific (Part B) physician or practitioner services furnished through a telecommunications system. Telehealth services substitute for an in-person encounter.

ORIGINATING SITES

An originating site is the location where a Medicare beneficiary gets physician or practitioner medical services through a telecommunications system. The beneficiary must go to the originating site for the services located in either:

- A county outside a Metropolitan Statistical Area (MSA)
- A rural Health Professional Shortage Area (HPSA) in a rural census tract

The Health Resources and Services Administration (HRSA) decides HPSAs, and the Census Bureau decides MSAs. To see a potential Medicare telehealth originating site's payment eligibility, go to HRSA's Medicare Telehealth Payment Eligibility Analyzer.

Providers qualify as originating sites, regardless of location, if they were participating in a Federal telemedicine demonstration project approved by (or getting funding from) the U.S. Department of Health & Human Services as of December 31, 2000.

Each December 31 of the prior calendar year (CY), an originating site's geographic eligibility is based on the area's status. This eligibility continues for a full CY. Authorized originating sites include:

- Physician and practitioner offices
- Hospitals
- Critical Access Hospitals (CAHs)
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs)
- Community Mental Health Centers (CMHCs)

Beginning July 1, 2019, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removes the originating site geographic conditions and adds an individual's home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder.

- Renal Dialysis Facilities
- Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis
- Mobile Stroke Units

Note: Medicare does not apply originating site geographic conditions to hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes when practitioners furnish monthly home dialysis ESRD-related medical evaluations. Independent Renal Dialysis Facilities are not eligible originating sites.

Beginning January 1, 2019, the Bipartisan Budget Act of 2018 removed the originating site geographic conditions and added eligible originating sites to diagnose, evaluate, or treat symptoms of an acute stroke. Go to MLN Matters® article, New Modifier for Expanding the Use of Telehealth for Individuals with Stroke to learn how to use the new modifier for billing.

DISTANT SITE PRACTITIONERS

Distant site practitioners who can furnish and get payment for covered telehealth services (subject to State law) are:

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs) and clinical social workers (CSWs)
  - CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.
- Registered dietitians or nutrition professional

TELEHEALTH SERVICES

You must use an interactive audio and video telecommunications system that permits real-time communication between you at the distant site, and the beneficiary at the originating site.

Transmitting medical information to a physician or practitioner who reviews it later is permitted only in Alaska or Hawaii Federal telemedicine demonstration programs.

CY 2019 Medicare Telehealth Services

Service	HCPCS/CPT Code
Telehealth consultations, emergency department or initial inpatient	G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406–G0408
Office or other outpatient visits	99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307–99310
Individual and group kidney disease education services	G0420–G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction furnished in the initial year training period to ensure effective injection training	G0108–G0109
Individual and group health and behavior assessment and intervention	96150–96154
Individual psychotherapy	90832–90838
Telehealth Pharmacologic Management	G0459
Psychiatric diagnostic interview examination	90791–90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90963
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90964
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90965
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older	90966
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age	90967
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 2–11 years of age	90968

CY 2019 Medicare Telehealth Services (cont.)

Service	HCPCS/CPT Code
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 12–19 years of age	90969
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	90970
Individual and group medical nutrition therapy	G0270, 97802–97804
Neurobehavioral status examination	96116
Smoking cessation services	G0436, G0437, 99406, 99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	G0396, G0397
Annual alcohol misuse screening, 15 minutes	G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	G0443
Annual depression screening, 15 minutes	G0444
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	G0446
Face-to-face behavioral counseling for obesity, 15 minutes	G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	99495
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	99496
Advance Care Planning, 30 minutes	99497
Advance Care Planning, additional 30 minutes	99498
Psychoanalysis	90845
Family psychotherapy (without the patient present)	90846
Family psychotherapy (conjoint psychotherapy) (with patient present)	90847
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	99355
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)	99356

CY 2019 Medicare Telehealth Services (cont.)

Service	HCPCS/CPT Code
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service)	99357
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit	G0438
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit	G0439
Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	G0508
Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	G0509
Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making	G0296
Interactive Complexity Psychiatry Services and Procedures	90785
Health Risk Assessment	96160, 96161
Comprehensive assessment of and care planning for patients requiring chronic care management	G0506
Psychotherapy for crisis	90839, 90840
Prolonged preventive services	G0513, G0514

A physician, NP, PA, or CNS must furnish at least one ESRD-related "hands on visit" (not telehealth) each month to examine the beneficiary's vascular access site.

TELEHEALTH SERVICES BILLING AND PAYMENT

Submit professional telehealth service claims using the appropriate CPT or HCPCS code.

If you performed telehealth services "through an asynchronous telecommunications system", add the telehealth GQ modifier with the professional service CPT or HCPCS code (for example, 99201 GQ). You are certifying the asynchronous medical file was collected and transmitted to you at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.

Submit telehealth services claims, using Place of Service (POS) 02-Telehealth, to indicate you furnished the billed service as a professional telehealth service from a distant site. As of January 1, 2018, distant site practitioners billing telehealth services under the CAH Optional Payment Method II must submit institutional claims using the GT modifier.

Bill covered telehealth services to your Medicare Administrative Contractor (MAC). They pay you the appropriate telehealth services amount under the Medicare Physician Fee Schedule (PFS). If you are located in, and you reassigned your billing rights to, a CAH and elected the Optional Payment Method II for outpatients, the CAH bills the telehealth services to the MAC. The payment is 80 percent of the Medicare PFS facility amount for the distant site service.

TELEHEALTH ORIGINATING SITES BILLING AND PAYMENT

HCPCS Code Q3014 describes the Medicare telehealth originating sites facility fee. Bill your MAC for the separately billable Part B originating site facility fee.

Note: The originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services when a CMHC serves as an originating site.

RESOURCES

Telehealth Services Resources

For More Information About...	Resource
Telehealth Services	CMS.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html CMS.gov/Medicare/Medicare-General-Information/Telehealth CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
Physician Bonuses	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246598.html

Hyperlink Table

Embedded Hyperlink	Complete URL
Health Professional Shortage Area	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses
Medicare Telehealth Payment Eligibility Analyzer	https://data.hrsa.gov/tools/medicare/telehealth
New Modifier for Expanding the Use of Telehealth for Individuals with Stroke	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10883.pdf
Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act	https://www.congress.gov/bill/115th-congress/house-bill/6

HELPFUL WEBSITES

American Hospital Association Rural Health Care
https://www.aha.org/advocacy/small-or-rural

Critical Access Hospitals Center
https://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html

Disproportionate Share Hospitals
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

Federally Qualified Health Centers Center
https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

Health Resources and Services Administration
https://www.hrsa.gov

Hospital Center
https://www.cms.gov/Center/Provider-Type/Hospital-Center.html

Medicare Learning Network®
http://go.cms.gov/MLNGenInfo

National Association of Community Health Centers
http://www.nachc.org

National Association of Rural Health Clinics
https://narhc.org

National Rural Health Association
https://www.ruralhealthweb.org

Rural Health Clinics Center
https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Rural Health Information Hub
https://www.ruralhealthinfo.org

Swing Bed Providers
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html

Telehealth
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth

Telehealth Resource Centers
https://www.telehealthresourcecenter.org

U.S. Census Bureau
https://www.census.gov

REGIONAL OFFICE RURAL HEALTH COORDINATORS

To find contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues, refer to CMS.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf.

CMS FINALIZED TELEHEALTH CHANGES TO PHYSICIAN FEE SCHEDULE CY 2019

Center for Connected Health Policy
The National Telehealth Policy Resource Center

On Nov. 1, 2018, the Center for Medicare and Medicaid Services (CMS) released their CY 2019 finalized revisions related to the Physician Fee Schedule (PFS). The final policy aims to modernize the healthcare system and help "restore the doctor-patient relationship" by reducing administrative burden. The changes related to telehealth are significant, as it not only expands Medicare telehealth services, but communicates a new interpretation by CMS of the applicability of their statutory requirements for reimbursement of remote communication technology as separate from telehealth, and adds new services based on this interpretation. For a more detailed analysis of these new policies, visit CCHP's website at cchpca.org.




Brief Communication Technology-based Service, e.g. Virtual Check-in

- When a physician or other qualified health care professional has a brief non-face-to-face check-in with a patient via communication technology to assess whether the patient's condition necessitates an office visit
- Reimbursed at $14
- Code G2012
- Copays apply
- Not labeled telehealth, therefore not subject to telehealth restrictions
- FQHC/RHCs will receive own code for this service
- Informed consent required

Asynchronous Remote Evaluation of Pre-Recorded Patient Information

- Remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology
- Must be an established patient
- Code G2010
- Copays apply
- Not labeled telehealth, therefore not subject to telehealth restrictions
- FQHC/RHCs will receive own code for this service
- Informed consent required

Interprofessional Internet Consultation

- Cover consultations between professionals performed via communications technology such as telephone or Internet
- 99446-99449, 99451, 99452
- Verbal consent and acknowledgement of cost sharing from patient required
- Limited to practitioners that can independently bill Medicare for E/M visits
- Not allowed for FQHC/RHC because AIR and PPS rates already includes costs of consults with other practitioners

Additional Changes

- Add HCPCS codes G0513 and G0514 as codes to be reimbursed if telehealth is used. Would be subject to the telehealth restrictions
- Made changes required by Bipartisan Budget Act of 2018
- For remote pyshiological monitoring: codes created and finalized to be reimbursed: 99453, 99454 and 99457
- For chronic care management: new code for reimbursement 99491

INTERIM FINAL RULE ON CHANGES BASED ON SUPPORT FOR PATIENT AND COMMUNITIES ACT
The SUPPORT for Patient and Communities Act required CMS to remove the originating site geographic requirements for telehealth services on or after July 1, 2019 for any existing Medicare telehealth originating site (except for a renal dialysis facility) for purposes of treating substance use disorder or co-occurring mental health disorder. Additionally, the home was made an eligible originating site for purposes of treating these individuals, however the home would not qualify for the facility fee. CMS has issued an interim final rule with comment period to implement these requirements. They note that the normal telehealth service code limitations still apply. CMS also is continuing to accept comments regarding the development of a separate bundled payment for an episode of care for treatment of Substance Use Disorders (SUD), which can include elements of Medication Assisted Therapy (MAT), including potentially web-based routine counseling. Comments on the interim final rule and bundled payments are being accepted for 60 days following this rule's publication (Nov. 23).

CCHP was created in 2008 by the California Health Care Foundation, who remains its lead funder.
The National Telehealth Policy Resource Center project is made possible by Grant #G22RH30365 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

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