TELEHEALTH POLICIES:
Federal & State

HRSA PROJECT OFFICER TRAINING CALL
May 16, 2019
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TELEHEALTH STATE-BY-STATE POLICIES, LAWS & REGULATIONS

Search by Category & Topic

**Medicaid Reimbursement**
- Live Video
- Store & Forward
- Remote Patient Monitoring Reimbursement

**Private Payer Reimbursement**
- Private Payer Laws
- Parity Requirements

**Professional Regulation/Health & Safety**
- Cross-State Licensing
- Consent
- Prescribing
- Misc (Listing of Practice Standards)
TELEHEALTH POLICY CONCERNS

- Reimbursement
  - Medicare & Medicaid
  - Private Payers
- Licensing
- HIPAA & Privacy
- Professional Regulation
  - State Professional Regulatory Boards
- Prescribing
SOCIAL SECURITY ACT OF 1835(m) or 42 USC 1395m

- Only Live Video reimbursed
- Store & Forward (Asynchronous) only for Alaska & Hawaii demonstration pilots
- Specific list of providers eligible for reimbursement
- Limited to rural HPSA, non-MSA, or telehealth demonstration projects
- Limited types of facilities eligible
- Limited list of reimbursable services, but CMS decides what can be delivered via telehealth and reimbursed
MEDICARE FEE-FOR-SERVICE/ORIGINAL MEDICARE

Telehealth Policy Only – Originating Sites

- Expanded to add Renal Dialysis Facilities & the home for ESRD-services ONLY.
- Rural limitation not apply for ESRD services in hospital-based or CAH-based renal dialysis centers, renal dialysis facilities or home.
- Acute stroke service via telehealth may take place in currently eligible originating sites and mobile stroke unit or any location deemed appropriate by Secretary. Renal Dialysis Facilities & home are excluded.
- For acute stroke diagnosis, evaluation and treatment of symptoms, originating site limitations not apply.
- Facility fee not given to home originating sites or in the case of acute stroke services, those sites exempted from the geographic limitations.
- A new modifier will be created for acute stroke
- Types of services and providers eligible to be reimbursed if providing telehealth services did NOT change
Telehealth Policy Only – Services

- Added codes for telehealth reimbursement
- CMS may add new codes for reimbursement every year
- Decision to add new codes depends on whether the services fall into one of two potential categories
- For CY 2019 added two codes:
  - G0513 and G0514 - Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes or for each additional 30 minutes
Telehealth Technologies used to deliver care, but not called a telehealth service

- Added codes for remote physiological monitoring:
  - CPT code 99453 - Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.
  - CPT code 99454- Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
  - CPT code 99457- Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.
MEDICARE – Communication Technology-Based Services

Services furnished remotely using communications technology are not considered “Medicare telehealth services” and are not subject to the restrictions articulated in section 1834(m) of the Act. ~ CMS, Federal Register, November 1, 2018.

• Brief Communication Technology-based Service or Virtual Check-In
• Remote Evaluation of Pre-Recorded Patient Information
• Interprofessional Internet Consultation
VIRTUAL CHECK-IN

• G2012 - Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

• May be done over phone
• Only for established patients
• Must have verbal consent
• Patient will be responsible for any co-payment/deductible
REMOTE EVALUATION OF PRE-RECORDED PATIENT INFORMATION

- G2010 - Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

- Only for established patients

- Patient will be responsible for any copayment/deductible
INTERPROFESSIONAL INTERNET CONSULTATION

- **99446 - 99449** - Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-31 minutes of medical consultative discussion and review (depending on code).

- **99452** - Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes.

- **99451** - Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient’s treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time.

- Verbal consent required
- Cost sharing with patient needs to be disclosed
- Can be through phone or internet
The SUPPORT for Patient and Communities Act required CMS to adjust their reimbursement policy of telehealth for treating individuals with SUDs or a co-occurring mental health disorder.

- Removed 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).
- Home was made an eligible originating site for purposes of treating these individuals, however the home would not qualify for the facility fee.
- Within 5 years a report of the impact of telehealth services on SUD must be submitted by the Secretary
OPIOIDS/SUBSTANCE USE DISORDER

OTHER SUD/OPIOID RELATED POLICIES

- Guidance by CMS given to states regarding options for receipt of federal funds for Medicaid covered treatment of SUD through telehealth
- Guidance by CMS on availability of federal funding in Medicaid coverage for SUD treatment services using telehealth through managed care and school-based health centers
- Within one year the DEA must have final regulations for a special registration to remotely prescribe Suboxone/Buprenorphine through telehealth
Medicare Advantage (MA) plans are now allowed to cover Part A and B services when delivered via telehealth.

MA plans decide what services can be offered, as long as they are services covered under Part A and B.

If the services are not typically covered under Part A and B, MA plans may offer those services via telehealth but will be covered under supplemental plans.

Must use credentialed, contracted network providers.

Modalities are broadly defined.

Geographic and facility restrictions found in Medicare fee-for-service do not apply.

Limitations on type of providers who can provide these additional telehealth benefits will continue to apply.

All relevant state laws will apply.

Not mandatory for MA plans to offer to cover more services beyond what is required in fee-for-service.

Does not go into effect until 2020.
MEDICAID REIMBURSEMENT BY SERVICE MODALITY

- **Live Video**
  - 50 states and DC

- **Store and Forward**
  - Only in 11 states

- **Remote Patient Monitoring**
  - 20 states

As of January 2019

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39 states and DC have telehealth private payer laws. Some go into effect at a later date.

Parity is difficult to determine:
- Parity in services covered vs. parity in payment
- Many states make their telehealth private payer laws “subject to the terms and conditions of the contract”
LICENSING

- Must be licensed in the state the patient is located
- Very few exceptions
- Nine states have a “telemedicine license” or exception for telehealth
- Compacts
  - Interstate Medical Licensure Compact (28 states, DC & Guam)
  - Enhanced Nurse Licensure Compact (30 states)
  - Physical Therapy Licensure Compact (23 states)
  - Psychology Interjurisdictional Compact (8 states)
HIPAA/PRIVACY

- Still held to the same standards
- Equipment alone cannot be HIPAA compliant
- HIPAA compliance is a combination of physical, administrative & technical safeguards
- Using telehealth may require you to think differently in order to be compliant
PRESCRIBING

• Federal Law – DEA/Controlled substances
• State licensing/regulatory boards have “telehealth practice standards”
• Common elements:
  • How to establish a “provider-patient relationship”
  • Standard of care the same as if the service provided in-person
  • Telehealth specific informed consent
  • Establishing when it’s appropriate to prescribe over telehealth
2019 STATE LEGISLATIVE TRENDS

2019 State Legislation So Far

- Broadband
- Cross-State Licensing
- Demonstrations, Grants & Pilot Projects
- Medicaid Reimbursement
- Network Adequacy
- Online Prescribing
- Other
- Private Payer Reimbursement
- Provider-Patient Relationship
- Regulatory, Licensing & Advisory Boards
- Substance Use Disorder
RESOURCES

Center for Connected Health Policy
www.cchpca.org

Telehealth Resource Center
www.telehealthresourcecenter.org
THANK YOU!