LEGAL IMPLICATIONS OF TELEHEALTH

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HEALTH LAW IS OUR BUSINESS.
Agenda

• Purpose and Structure of Telehealth Webinar Series
• Credentialing Issues
• Payment Issues
• Questions
Purpose and Schedule for Calls

- Present current legal and business issues associated with telehealth
- Discuss opportunities for using telehealth to:
  - Improve access to care;
  - Improve outcomes from care;
  - Improve health; and
  - Reduce overall costs for care
- Discuss opportunities to reduce legal and business barriers to broader use of telehealth
Potential Goal for Series

Is there consensus on one or more approaches to reducing legal or reimbursement barriers where a coalition could be formed with the purpose of advocating legal or regulatory changes to promote telehealth?
Future Webinars

• Second Webinar
  – Licensure Issues
  – Technology Issues
  – Paying for the Technology – Stark Law and Anti-Kickback Statute Issues

• Third Webinar
  – Legal Agreements
  – Case Studies
  – Potential Solutions to Current Barriers
The Long and Winding Road of Telemedicine Credentialing

History of Credentialing Telemedicine Providers

• 2001: TJC adopted a standard that required practitioners to be credentialed at the facility where care was delivered
• 2003: TJC introduced “credentialing by proxy”
  – CMS disagreed and said telemedicine providers were subject to the same standards as all other providers
Telemedicine Credentialing

- 2008: Credentialing by proxy called into question by MIPPA
  - MIPPA revoked TJC’s unique statutory deeming status and required TJC to periodically reapply for deeming authority
- 2009: TJC revised standards consistent with CoPs
- 2010: CMS Proposed Regulations released; did not go as far as original TJC credentialing by proxy
- May 2011: CMS reversed course and allowed credentialing by proxy, now better called “reliance credentialing”
- 2011 and 2012: TJC realigned standards with CMS, but retains some differences
  - Must the originating site be TJC accredited?
  - Some telemed EPs noted as risk areas subject to FSA
Telemedicine Credentialing

*Conditions of Participation*

Relying on a Distant Site Hospital

- Written agreement between hospitals
- Agreement specifies responsibility of distant site to meet credentialing/privileging CoPs
- Agreement specifies distant site furnishes contracted service to hospital in a manner that permits receiving hospital to comply with CoPs for contracted services
Telemedicine (CoPs cont'd)

Relying on a Distant Site Hospital

- Distant site must be Medicare-participating hospital
- Provider is privileged at distant site, which provides current list of Provider's privileges
- Provider holds a license issued or recognized by the state of receiving hospital
- Receiving hospital conducts and shares internal reviews of Provider's performance with distant site hospital (at a minimum, all adverse events and complaints)
Telemedicine (CoPs cont'd)

Relying on a Distant Site Telemedicine Entity

- Similar to the above, and hospital’s governing body must ensure, through written agreement, that the telemedicine entity's credentialing/privileging process and standards meet medical staff and governing body standards of CoPs
Telemedicine Credentialing

• The Joint Commission
  – Aligned with the Medicare CoPs, but some differences
• HFAP and DNV
  – Largely identical to CoP requirements
• But what about state law?
  – Most state hospital licensure laws still do not affirmatively adopt the reliance credentialing approach
  – It was addressed in the comprehensive California telehealth legislation by adopting the CMS rules into state law
  – Risk management assessment if state law silent
The California Fix to State Law

• Section 2290.5 of the Business and Professions Code

(g) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, “telehealth” shall include “telemedicine” as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.
Telehealth Payment

• Medicare
  – No coverage for patients in urban areas
  – Specific originating site (patient end) requirement and limited set of covered services
  – Each year, incremental coverage expansion can occur
    • For 2013, CMS is adding a series of codes covering select behavioral health services for alcohol and substance abuse, depression screening, STD counseling, behavioral therapy for cardiovascular disease and obesity counseling

• Medicaid: most state plans have some coverage – varies state by state
Telehealth Payment

• Private payers
  – Varies state by state
  – Varies payer by payer
  – Some states have enacted telehealth parity coverage mandating the coverage and payment for telehealth
    • State laws differ: examples discussed below
    • Contract carve-outs often reaffirmed
    • Gradations of the continuation of the primacy of face-to-face medicine
• List below current through August 2012
State Law Telehealth Payment Parity

- **California**: Cal. Ins. Code § 10123.85
- **Colorado**: Colo. Rev. Stat. § 10-16-123
- **Georgia**: O.C.G.A. § 33-24-56.4
- **Maine**: 24-A M.R.S.A. § 4316
- **Maryland**: Code of Maryland: Article Insurance § 15-139
- **Massachusetts**: Mass. Gen. Laws ch. 175, § 47BB
State Law Telehealth Payment Parity

- **Michigan**: MCL Chapter 550 § 550.1401k and Chapter 500 § 500.3476
- **Oklahoma**: OK Stat. 36 Sec. 6802, 6803
- **Oregon**: O.R.S. § 743A.058
- **Texas**: V.T.C.A., Insurance Code § 1455.004
- **Vermont**: Sec. 1. 8 V.S.A. Chapter 107, Subchapter 14 § 4100k
- **Virginia**: VA Code Ann. § 38.2-3418.16
The Kentucky Example


(1) (a) A health benefit plan shall not exclude a service from coverage solely because the service is provided through telehealth and not provided through a face-to-face consultation if the consultation is provided through the telehealth network established under KRS 194A.125. A health benefit plan may provide coverage for a consultation at a site not within the telehealth network at the discretion of the insurer.

(b) A telehealth consultation shall not be reimbursable under this section if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.

(2) Benefits for a service provided through telehealth required by this section may be made subject to a deductible, copayment, or coinsurance requirement. A deductible, copayment, or coinsurance applicable to a particular service provided through telehealth shall not exceed the deductible, copayment, or coinsurance required by the health benefit plan for the same service provided through a face-to-face consultation.

(3) Payment made under this section may be consistent with any provider network arrangements that have been established for the health benefit plan.

(4) The department shall promulgate an administrative regulation in accordance with KRS Chapter 13A to designate the claim forms and records required to be maintained in conjunction with this section.
The Michigan Example

MCL Chapter 550 § 550.1401k (also Chapter 500 § 500.3476 for other insurance can HMOs)

(1) A group or nongroup health care corporation certificate shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the health care corporation. Telemedicine services shall be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located. Telemedicine services are subject to all terms and conditions of the certificate agreed upon between the certificate holder and the health care corporation, including, but not limited to, required copayments, coinsurances, deductibles, and approved amounts.

(2) As used in this section, "telemedicine" means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine under this section, the health care professional must be able to examine the patient via a real-time, interactive audio or video, or both, telecommunications system and the patient must be able to interact with the off-site health care professional at the time the services are provided.

(3) This section applies to a certificate issued or renewed on or after January 1, 2013.
A Snapshot for Medicare

• Assumptions
  – Patients located in a Critical Access Hospital (Rural)
  – Advanced Practice Provider (APP) physically present in the CAH with the patients
  – Distant site consulting physicians located in an affiliated hospital remote from the CAH
  – Services delivered are “on the list” of Medicare-covered telehealth
  – Responsible practitioner of record with admitting privileges at the hospital and within state law scope of practice is participating
    • In many states, this may not be the APP
<table>
<thead>
<tr>
<th>Patient Status</th>
<th>Nurse Practitioner (APP) at CAH</th>
<th>Telehealth Practitioner at Distant Site</th>
<th>Telehealth Facility Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission (telehealth services)</td>
<td>Medicare does not reimburse practitioners at the originating site for telehealth services/telepresenter activities.</td>
<td>Medicare pays for reasonable and medically necessary initial inpatient telehealth consultation services. A distant site practitioner can bill for initial inpatient telehealth consultations (HCPCS codes G0425 – G0427).</td>
<td>CAH may bill a facility fee equal to $24.43 for 2013.</td>
</tr>
<tr>
<td>Subsequent Examinations (telehealth services)</td>
<td>Medicare does not reimburse practitioners at the originating site for telehealth services.</td>
<td>A distant site practitioner can bill for reasonable and medically necessary follow-up inpatient telehealth consultations (HCPCS codes G0406 – G0408) and subsequent hospital care services (HCPCS codes 99231 – 99233; limit of one visit every three days).</td>
<td>CAH may bill a facility fee equal to $24.43 for 2013.</td>
</tr>
<tr>
<td>Daily/Multi-Disciplinary Rounds</td>
<td>Any medically necessary services provided by the APP as part of the daily or multidisciplinary rounds would be reimbursed at 85% of the fee schedule amount.</td>
<td>Daily or multidisciplinary rounds are not covered by Medicare when provided via telehealth technology.</td>
<td>N/A</td>
</tr>
<tr>
<td>Discharge</td>
<td>The APP would perform and bill for any discharge services and would be reimbursed at 85% of the fee schedule amount.</td>
<td>Discharges are not covered by Medicare when provided via telehealth technology.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Please visit the Hall Render Blog at [http://blogs.hallrender.com](http://blogs.hallrender.com) for more information on topics related to health care law.

For questions regarding the legal implications of telehealth, please contact us at [telehealth@hallrender.com](mailto:telehealth@hallrender.com) or as listed below. Today’s webinar recording and slides will be sent to participants in the near future.

Thank you for participating in a Hall Render webinar; we hope you will attend future events.

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