Making the Right Call on Telemedicine:
Legal and Regulatory Guidelines

Presented by Yarnell Beatty
Senior Vice President and General Counsel, Tennessee Medical Association

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This program will provide an overview of what state and federal laws govern activities around telehealth or telemedicine generally, including changes the government has made to the regulation of telemedicine for the duration of the 2020 coronavirus pandemic.

FACULTY

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TARGET AUDIENCE

The intended audience for this program is healthcare professionals who manage patients in an office, clinic, or urgent-care setting, including physicians, nurses, and administrators.

EDUCATIONAL OBJECTIVES

At the conclusion of activity, participants should be able to:

- Define telemedicine in terms of current regulation
- Know what license(s) is needed to conduct telemedicine depending on where the patient is
- Identify the proper standard of care
- Understand when a physician-patient relationship is established by telemedicine
- Understand what elements Medicare requires for telemedicine services in order to operate legally and avoid payment audits
- Know what current regulation has been relaxed during the COVID -19 emergency

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Disclosure to Learners

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Senior Vice President and General Counsel

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Telemedicine Presentation2020 Outline

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i. [SLIDE 3] **Module 2: Overview of Tennessee State Law** – The goals of this module are to: 1) provide you an overview of what state and federal laws govern activities around telehealth or telemedicine generally. 2) I will also provide an overview of the changes government has made to the regulation of telemedicine for the duration of the 2020 coronavirus pandemic.

a. [SLIDE 5] What is the **definition**?

i. To help understand what is meant by "telemedicine," it is best to start with what telemedicine *is not*. Encounters between a doctor and patient via a telephone conversation, email, text message, or fax are *not* considered telemedicine under state law. [TCA § 56-7-1002, and § 63-1-155].

ii. "Telehealth" or "telemedicine" are defined in a 2014 law, TCA § 56-7-1002 located in the state insurance code, and in a 2015 law, TCA § 63-1-155, located in the health professional licensure code.

a. TCA § 56-7-1002 is in the insurance code. "Telehealth":
    a. Means the use of real-time, interactive audio, video telecommunications or electronic technology, or store-and-forward telemedicine

services by a healthcare services provider to deliver healthcare services to a patient within the scope of practice of the healthcare services provider when:

i. Such provider is at a qualified site other than the site where the patient is located; and

ii. The patient is at a qualified site, at a school clinic staffed by a healthcare services provider and equipped to engage in telecommunications, or at a public elementary or secondary school staffed by a healthcare services provider and equipped to engage in the telecommunications; and

b. Does not include:

i. An audio-only conversation;

ii. An electronic mail message or text;

iii. A facsimile transmission; or

iv. The transfer of patient medical information to a person in another state who is not licensed to practice medicine or osteopathy in the state of Tennessee, using any electronic, telephonic or fiber optic means or by any other

method, constitutes the practice of medicine or osteopathy and if such information is employed to diagnose and/or treat, any person physically located within the state of Tennessee, it is not telemedicine.[TCA 63-1-155(d) referring to TCA 63-6-231 and 63-6-204(b)(21)]

b. TCA § 63-1-155(2) is in the general health related professions portion of the code.
    a. "Telehealth" or "telemedicine" means, notwithstanding any restriction imposed by § 56-7-1002, the use of real-time audio, video, or other electronic media and telecommunications technologies that enable interaction between the healthcare provider and the patient, or also store-and-forward telemedicine services, [as defined by § 56-7-1002(a)], for the purpose of diagnosis, consultation, or treatment of a patient in another location where there may be no in-person exchange.

c. The Board of Medical Examiners' rule [Rule 0880-02-.16(g)]ties it up neatly by defining "Telemedicine" as:
    a. The practice of medicine using electronic communication, information technology or other means, between a licensee in one location and a patient in another location. Telemedicine is not an audio only telephone conversation, email/instant messaging conversation or fax. It typically involves the application of secure video conferencing or store-and-forward to provide or support healthcare delivery by replicating the interaction of a traditional encounter between a provider and a patient.

So, those are the 3 definitions in state law.

b. [SLIDE 6] When is a health care **provider-patient relationship** created through a telemedicine encounter? [TCA § 63-1-155(b)]. Three concepts will paint the picture for you.
    i. One of these have to occur:
        a. The health care provider affirmatively undertakes to diagnose and treat the patient; or
        b. The health care provider participates in the diagnosis and treatment of the patient (consultation).
        c. And there must be mutual consent and mutual communication, except in an emergency, between the patient and the provider. For example, if the patient is

having a stroke and cannot consent, his consent is implied when a health care provider is treating or advising as to the care for the stroke via telemedicine. A physician-patient relationship exists.

d. Mere receipt of patient health information by a health care provider does not create a provider-patient relationship unless a prior provider-patient relationship existed.

c. [SLIDE 7] What does the law say about **standard of care** when telemedicine is used?

i. Telehealth providers shall be held to the same standard of care as healthcare services providers providing the same healthcare service through in-person encounters. [TCA § 56-7-1002(b)].

ii. TCA § 63-1-155(c)(1) says:

a. A healthcare provider who delivers services through the use of telehealth shall be held to the same standard of professional practice as a similar licensee of the same practice area or specialty that is providing the same healthcare services through in-person encounters.

b. Licensing boards are actually prohibited from establishing a more restrictive standard of professional practice for the practice of telehealth than that specifically authorized by the provider's practice act. This law was specifically aimed at the Board of Medical Examiners which was in the process of promulgating a blanket rule that would have disallowed prescribing of controlled drugs via telemedicine.

c. Bottom line, the statute creates parity in standard of care between telemedicine and the provision of the same service in-person.

There are additional provisions in state law:

d. Telehealth services have to comply with the State treatment guidelines for the prescribing of opioids.
e. TCA § 63-1-155 does not apply to pain management clinics in Tennessee. Licensed pain clinics cannot use telemedicine to prescribe drugs for chronic non-malignant pain treatment.
    a. CV19 Change: Gov. Lee's Executive Order # 15 waives this requirement and allows pain clinics to use telemedicine during the COVID-19 emergency.
f. Telemedicine cannot be used to prescribe any drug to cause a medical abortion. [TCA § 63-6-155(e) referring to TCA § 63-6-241].

d. [SLIDE 8] **Health Insurance and Telehealth.** TCA § 56-7-1002 is located in Title 56, the state insurance code. It addresses telehealth in terms of how it is treated by the health insurance industry.
    i. TCA § 56-7-1002 applies to:
        a. Commercial health plans; and
        b. TennCare MCOs.

    ii. TCA § 56-7-1002 does <u>not</u> apply to:

a. Accident-only, specified disease, or hospital indemnity plans;
b. Affordable Care Act exchange plans;
c. ERISA plans
d. Medicare or Medicare Advantage plans
e. Government veteran or military health insurance
f. Any disability income, long-term care, or other limited benefit hospital insurance policies.

iii. [SLIDE 9] Specifies that a telehealth provider who seeks to contract with, or who has contracted with, a health insurance entity to participate in the health insurance entity's network shall be subject to the same requirements and contractual terms as a healthcare services provider in the health insurance entity's network. This deals with requirements for a telehealth provider to be in-network with an insurer – like credentialing, agreement to be subject to utilization review, etc. [TCA § 56-7-1002(c)]

iv. The statute makes several requirements of a health insurance entity. [TCA § 56-7-1002(d)] I want to go over these.

a. Provide coverage under a health insurance policy or contract for covered healthcare services delivered through telehealth. [TCA § 56-7-1002(d)(1)]. As I read it, this is a requirement to make telehealth covered under a patient's health care policy; this is separate from requiring payment for it or from dictating how much a plan is required to reimburse;

b. [SLIDE 10] Reimburse a healthcare services provider for the diagnosis, consultation, and treatment of an insured patient for a healthcare service covered under a health insurance policy or contract that is provided through telehealth without any distinction or consideration of the geographic location or any federal, state, or local designation, or classification of the geographic area where the patient is located. [TCA § 56-7-1002(d)(2)]. I interpret that to mean that a health plan cannot have coverage requirements or reimbursement policies for telehealth services that vary with the qualified site location where the patient is located, such as a doctor's office versus a hospital versus a school clinic. I do not interpret it to mean that the health insurer is *required* to reimburse for telehealth services at whatever geographic location the patient happens to be.

c. [SLIDE 11] The definition in the insurance code adds a twist that I want to clarify for you. For purposes of what I'm going over now and for reimbursement, the definition has requirements as to *where* the health care provider is located and requirements as to *where* the patient is located. So, when reimbursement is required by a health plan, (1) the health care provider has to be at a "qualified site" and (2) not be where the patient is located.

    a. What is a qualified site where the <u>health care provider</u> must be located? [TCA § 56-7-1002(a)(4)]

1. Office of a Tennessee health care provider
2. Tennessee licensed mental health facility
3. Tennessee licensed hospital
4. Facility designated as a rural health clinic under Medicare
5. Federally Qualified health Center
6. Or, *any other location deemed acceptable by the health insurance entity*

b. [SLIDE 12] Where must the patient be located according to the definition in the insurance code? [TCA § 56-7-1002(a)(6)(A)(i) and (ii)]
   1. A qualified site (1-6 above) different from where the health care provider is located
   2. A school clinic staffed by a health care provider and equipped to engage in telecommunications
   3. A public elementary or secondary school staffed by a health care provider and equipped to engage in telecommunications

c. Noticeably absent from the list of patient qualified sites is the patient's home. In order to get reimbursed for the provision of telehealth to a patient's home, the health insurance company has to agree to do so.
   i. CV19 Change: In response, some health plans are reimbursing when the patient is at home.

d. A health insurance company cannot exclude a service from coverage solely because it is provided through telehealth instead of in-person; [TCA § 56-7-1002(d)(3)] and

v. Reimburse healthcare services providers who are out-of-network for telehealth care services under the same reimbursement policies applicable to other out-of-network healthcare services providers. [TCA § 56-7-1002(d)(4)]

vi. Health insurance companies are not required to pay total reimbursement for a telehealth encounter, including the use of telehealth equipment, in an amount that exceeds the amount that would be paid for the same service provided by a healthcare services provider in an in-person encounter. They can pay more for telehealth, but they don't have to. [TCA § 56-7-1002(f)]

vii. The rest of the provisions are governed by the terms and conditions of provider contracts. [TCA § 56-7-1002(g)]

e. [SLIDE 13] **Licensure.** - Unless an exemption applies, a physician practicing medicine on a patient located in Tennessee must be licensed to practice medicine in Tennessee.

i. [SLIDE 14] TCA § 63-1-155(g)(1) requires that a physician have a Tennessee medical license in order to practice telemedicine in Tennessee. Jurisdiction is determined by the location of the patient. If the patient is in Tennessee, the physician, even if located outside of Tennessee, must have a Tennessee medical license. [Rule 0880-2-.16]

ii. The medical board used to issue "telemedicine licenses" to physicians out-of-state who practiced telemedicine on Tennessee patients. The board stopped doing that on October 31, 2018.

iii. Tennessee telemedicine licensees had to either:

1. Transfer the telemedicine license to a full medical license before October 31, 2018; or
2. Keep the Tennessee telemedicine license *only if*:
    a. They timely renew it every two years;
    b. Maintain current ABMS specialty certification;
    c. Limits telemedicine practice to "the provision of medical interpretation services" in the area of specialty board certification; and
    d. Not prescribe drug

iv. It makes the most sense just to obtain a full Tennessee license.

f. [SLIDE 15] **Delivering Telehealth in Tennessee –** The next topic is limited in scope to the practice of telemedicine by physicians. Besides the laws I've gone over previously, the actual practice of telemedicine is primarily governed by rules that were promulgated by the Tennessee Board of Medical Examiners and were effective on October 31, 2016.

i. **Conditions on Telemedicine Practice.** 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.

ii. "Facilitator" is defined in the BME rules as "an individual, often affiliated with a local system of care, or a parent or legal guardian of the patient.

a. A facilitator is required to be present with the patient during a telemedicine encounter when the patient is under 18 years of age, except as otherwise authorized by law. [Rule 0880-02-.16(8)]

b. "As otherwise provided by law" would include situations where the minor patient may lawfully consent to treatment; for example an emancipated minor. [For additional information, see TMA's *Treatment of Minors Guide* for the instances when a minor may consent to treatment without parental consent].

iii. [SLIDE 16] If no facilitator is present with the patient [Rule 0880-02-.16(6)(a)(1)]:

a. 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
b. The patient must transmit all relevant health information at the level of store-and forward technology or secure video conferencing; and
c. 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].

iv. If a facilitator is present with the patient [Rule 0880-02-.16(6)(a)(2)]:

a. 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
b. The facilitator must identify himself or herself, role, and title to the patient and the remote physician; and
c. 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].

v. [SLIDE 17] Medical Record and Documentation [Rule 0880-02-.16(6)(b)]

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

vi. [SLIDE 18] Quality of transmitted information [Rule 0880-02-.16(60(d)]

   a. If the information transmitted through telemedicine is not of sufficient quality or does not contain adequate information for the physician to form an opinion, the physician must:
      a. Declare he/she cannot form an opinion to make an adequate diagnosis; and
      b. Request direct referral of the patient for inspection and actual physical examination, request additional data, or recommend the patient be evaluated by the patient's primary physician or other local health care provider.
      c. Document this if it occurs.

vii. [SLIDE 19] Prescribing. The extent to which a physician can prescribe using telemedicine is based on the type of license she has:

a. Telemedicine license – no prescribing.

b. Full license – prescribing is allowed under certain restrictions and limitations.

    a. Controlled or Non-Controlled Substances. [Rule 0880-02-.14(6)(e)(3) and (7)(a)]. Before prescribing or dispensing *any* drug to any individual by any means, the physician must:

        i. Perform an appropriate history and physical examination;

        ii. Make a diagnosis upon the examinations and all diagnostic and laboratory tests consistent with good medical care;

        iii. Formulate and discuss a therapeutic plan with the patient, as well as the basis for the plan, the risks and benefits of various treatment options;

        iv. Insure availability of the physician or coverage for the patient for appropriate follow-up care.

        v. Cannot prescribe a drug based solely on answers to a set of questions; [Rule 0880-02-.14(7)(c)]

        vi. Governed by the state chronic pain guidelines which prohibits the treatment of chronic pain through telemedicine.

b. [SLIDE 20] Exceptions to the prior history and physical requirements [Rule 0880-02-.14(7)(b)].
    i. Admission orders for a newly hospitalized patient;
    ii. For a patient of another physician for whom the prescriber is taking calls;
    iii. For short term continuation medications for a new patient prior to the first appointment;
    iv. For established patients the physician does not feel requires a new physical examination before issuing a new prescription;
    v. Treatment of documented Chlamydia trachomatis.

c. Pain management clinics – no prescribing using telemedicine. [TCA 63-1-155(d)]
d. Cannot prescribe to cause a medical abortion using telemedicine. [TCA 63-1-155]

ii. [SLIDE 21] **Federal Law Legal and Regulatory Requirements** – Our goals are to have a basic understanding of how telemedicine is regulated in terms of Medicare and other federal government programs as well as the waivers and exceptions made to the general regulations, effective March 6, 2020, in order to help providers combat the Covid-19 crisis.

a. Medicare

i. General Requirements:

a. [SLIDE 22] Telehealth services in the Medicare program must be provided via a two-way, interactive communications system (which may include a telephone that has audio and visual two-way capabilities).

a. CV19 Change: The HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.

b. [SLIDE 23] An "originating site" (this is where the *patient* is located) must be in a rural or health professional shortage area. Medicare will only pay for telehealth visits when the patient is in a designated rural area and when they leave their home and go to a clinic, hospital, or certain other types of medical facilities for the service.

a. CV19 Change: Waived the requirement that an "originating site" be in a rural or health professional shortage area.

b. CV19 Change: Patient can be in his/her home for dates of service starting March 6, however, the provider will not receive an originating site fee.

c. [SLIDE 24] Physician must be located in the state in which the patient is located.

a. CV19 Change: CMS has waived any requirement that a physician or other healthcare professional be licensed in the state "in which they provide services."

d. Physician must have a prior relationship with the patient in order to utilize telehealth.
    a. CV19 Change: CMS will not audit claims submitted pursuant to the waivers to ensure a practitioner's compliance with the prior-existing relationship requirement.
e. [SLIDE 25] The use of telehealth does not change the out of pocket costs for beneficiaries with Original Medicare. Beneficiaries are generally liable for their deductible and coinsurance;
    a. CV19 Change: however, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

ii. [SLIDE 26] Services Available by Telehealth: Three basic services include virtual check-ins, E-visits, and telehealth visits.
    a. Virtual check-ins: Brief 5–10 minute visits between a practitioner and an established patient to determine whether an in-office visit is necessary.
        a. The patient must initiate the communications with the healthcare provider. However, it is permissible

for the provider to educate patients about the availability of virtual check-ins.

b. The patient has to verbally consent to a telehealth visit.
c. Virtual check-ins may only take place between established physician-patients.
    i. CV19 Change: Clinicians can provide virtual check-in services (HCPCS codes G2010, G2012) to *both* new and established patients.
d. The virtual check-in cannot be related to any visit within the previous 7-days or 24 hours afterwards.
e. Coinsurance and deductible are applicable.
f. CV19 Change: No geographic limitation on patient.
g. CV19 Change: Applies to all diagnoses (COVID-19 and non COVID-19).

b. [SLIDE 27] E-visits
    a. Provided through physician's online portal.
        i. CV19 Change: Physicians and others can provide certain services by telephone to their patients
    b. It must be initiated by the patient.
    c. Requires an established physician-patient relationship.
    d. The patient has to verbally consent to the visit.
    e. All locations (including patient home) & all geographic locations

f. Part B benefit but coinsurance & deductible applies.
g. CV19 Change: Applies to all diagnoses (COVID-19 and non COVID-19)

c. [SLIDE 28] Medicare Telehealth Visits
    a. Medicare patients may use telecommunication technology for office, hospital visits and other services that generally occur in-person.
    b. The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home.
    c. Providers must be licensed in the state where they are providing services.
        i. CV19 Change: Temporarily waiving (1135 waiver) license requirement. Still must be licensed in *a* state.
        ii. CV Change: TN Governor Executive Order # 15 waived the TN license requirement and any licensed health care provider can utilize telehealth.
    d. Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists,

clinical social workers, registered dietitians, and nutrition professionals.

e. [SLIDE 29] Must have prior-existing patient-provider relationship.
    i. CV19 Change: To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.
    ii. CV19 Change: These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.
f. CV19 Change: Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.

g. Patients must generally travel to, or be located in, certain types of originating sites such as a physician's office, skilled nursing facility or hospital for the visit.

    i. CV19 Change: Effective for services, starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency,

Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.

h. The Medicare coinsurance and deductible would generally apply to these services.

i. CV19 Change: However, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

d. Remote patient monitoring
    a. CV19 Change: Clinicians can provide remote patient monitoring services to both new and established patients. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease.

iii. Frequency Limitations for Telehealth Services. The best way to illustrate these is by example. I'll go over a few to give you the idea.
    a. A subsequent inpatient visit can be furnished via Medicare telehealth only once every three days;
        a. CV19 Change: A subsequent inpatient visit can be furnished via Medicare telehealth, without the

limitation that the telehealth visit is once every three days (CPT codes 99231-99233);

b. A subsequent skilled nursing facility visit can be furnished via Medicare telehealth visit only once every 30 days
    a. CV19 Change: A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310)
c. Critical care consult codes may be furnished to a Medicare beneficiary by telehealth only once per day.
    a. CV19 Change: Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (CPT codes G0508-G0509).

d. For Medicare patients with End Stage Renal Disease (ESRD), clinicians must have one “hands on” visit per month for the current required clinical examination of the vascular access site.
    a. CV19 Change: For Medicare patients with End Stage Renal Disease (ESRD), clinicians no longer must have one “hands on” visit per month for the current required clinical examination of the vascular access site.
e. For Medicare patients with ESRD, individuals must receive a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial 3 months of home dialysis

and at least once every 3 consecutive months after the initial 3 months.

a. CV19 Change: For Medicare patients with ESRD, we are exercising enforcement discretion on the following requirement so that clinicians can provide this service via telehealth: individuals must receive a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial 3 months of home dialysis and at least once every 3 consecutive months after the initial 3 months.

f. CV19 Change: To the extent that a National Coverage Determination (NCD) or Local Coverage Determination (LCD) would otherwise require a face-to-face visit for evaluations and assessments, clinicians would not have to meet those requirements during the public health emergency.

g. CV19 Change: Annual consent for the use of telehealth services may be obtained at the same time, and not necessarily before, the time that services are furnished.

h. 42 CFR 483.30 requires physicians and non-physician practitioners to perform in-person visits for nursing home residents.

a. CV Change: Physician visits: CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.

b. Long Term Care Nursing Home Telehealth and Telemedicine Toolkit is available from CMS.

iv. There are applicable cost-sharing obligations of Medicare beneficiaries receiving telehealth services.

a. CV19 Change: The OIG announced that it would not bring an enforcement action under the federal Anti-Kickback Statute or Civil Monetary Penalties Law against any practitioner who waives patients' cost-sharing obligations during the current public health emergency.

v. Application of HIPAA

a. There are applicable HIPAA requirements for practitioners providing telehealth services in good faith using any non-public facing remote communication product.

a. Ensure your technology vendors can protect protected health information from unauthorized disclosure, such as utilizing encryption and privacy modes when feasible.

b. Patients should be made aware of, and should consent to, potential risks to the privacy and security of their personal information that are inherent to telehealth.

c. Have business associate agreements with telehealth providers.

i. CV Change: OCR has also specified that it will not impose penalties against providers for the lack of a business associate agreement (BAA) with non-public facing

video communication vendors for the use of telehealth during the COVID-19 pandemic. Notify patients of privacy risks of the use of non-public-facing technology.

d. CV19 Change: OCR will waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth by covered health care providers.

vi. [SLIDE 30] Prescribing

a. Prescriptions for controlled substances based on telemedicine visits must be predicated on *prio*r in-person medical evaluations, [subject to certain exceptions, under the Ryan Haight Online Pharmacy Consumer Protection Act of 2008]

a. CV19 Change: During the pandemic, DEA-registered practitioners may issue prescriptions for all Schedule II-V controlled substances to patients for whom prior in-person medical evaluations have not been conducted as long as all of the following certain conditions are met:

i. The prescription must be issued for a legitimate medical purpose by a

practitioner acting in the usual course of the practitioner's professional practice.

ii. The telemedicine communication platform must use a real-time, two-way communication system with both audio and video capabilities.

iii. The practitioner must act in accordance with applicable federal and state law.

b. DEA requires that a prescriber hold a DEA registration in every state where the individual prescribes controlled substances.

i. CV19 Change: For the duration of the COVID-19 pandemic, practitioners will not be required to obtain additional DEA registrations in states where the prescribing occurs if state-level action (or waiver) permits the practitioner to dispense controlled substances in such state(s).

c. Controlled Substances by Telemedicine. 21 USCA 829 – Includes in definition of "covering practitioner." This is a practitioner who conducts a medical evaluation by telemedicine at the request of a practitioner who has conducted at least 1 in-person or telemedicine medical evaluation of the patient within the previous 24 months; and is temporarily unavailable to conduct the evaluation of the patient.

d. Disallows a partial fill of a Schedule II controlled substance by a practitioner engaged in telemedicine.

vii. Additional Telehealth Services During the COVID-19 Emergency:

a. Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
b. Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217- 99220; CPT codes 99224- 99226; CPT codes 99234- 99236)
c. Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238-99239)
d. Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316)
e. Critical Care Services (CPT codes 99291-99292)
f. Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327- 99328; CPT codes 99334-99337)
g. Home Visits, New and Established Patient, All levels (CPT codes 99341- 99345; CPT codes 99347- 99350)
h. Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468- 99473; CPT codes 99475-99476)
i. Initial and Continuing Intensive Care Services (CPT code 99477- 994780)

j. Care Planning for Patients with Cognitive Impairment (CPT code 99483)

k. Psychological and Neuropsychological Testing (CPT codes 96130- 96133; CPT codes 96136- 96139)

l. Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161- 97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)

m. Radiation Treatment Management Services (CPT codes 77427)

n. Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.

o. A complete list of all Medicare telehealth services can be found here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

viii. Part B Special Payment Rules. 42 USCA 1395m –

a. Requires Medicare Part B payment for telehealth services that are furnished via a telecommunications system by a physician or a practitioner to an eligible telehealth individual as long as the physician or practitioner providing the telehealth service is not at the same location as the beneficiary.

b. Payment to a physician or practitioner located at a distant site that furnishes a telehealth service shall be an amount equal to the amount that such physician or practitioner would have been paid had such service been furnished without the use of a telecommunications system.

c. Requires a facility fee payment to the originating site.

d. Telepresenter at original site is not required unless it is medically necessary (as determined by the physician or practitioner at the distant site). The term "originating site" means only those sites described in clause (ii) at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system and only if such site is located-- in an area that is designated as a rural health professional shortage area under section 254e(a)(1)(A) of this title; in a county that is not included in a Metropolitan Statistical Area; or from an entity that participates in a Federal **telemedicine** demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.

ix. Eligible originating sites:

a. The office of a physician or practitioner.

b. A critical access hospital (as defined in section 1395x(mm)(1) of this title).

c. A rural health clinic (as defined in section 1395x(aa)(2) of this title).

d. A federally qualified health center (as defined in section 1395x(aa)(4) of this title).
e. A hospital (as defined in section 1395x(e) of this title).
f. A hospital-based or critical access hospital-based renal dialysis center (including satellites).
g. A skilled nursing facility (as defined in section 1395i-3(a) of this title).
h. A community mental health center (as defined in section 1395x(ff)(3)(B) of this title).

[Questions?]