The CTRC Telehealth Program Developer Kit

A Roadmap For Successful Telehealth Program Development

CALIFORNIA TELEHEALTH RESOURCE CENTER

Your resource for telehealth success

caltrc.org | 877.590.8144

Part of the OCHIN Family of Companies
Introduction

The California Telehealth Resource Center (CTRC), a resource center specializing in telemedicine and telehealth program development, responds to hundreds of assistance requests from around the globe. We often hear from organizations interested in starting telehealth programs who think telehealth sounds valuable but need to know what steps to take to get a telehealth program started.

The CTRC Program Developer was designed to answer that need. The genesis of this kit is the implementation methodology developed for the University of California schools and hospitals, as well as the safety net clinic referring partners throughout the state. It was necessary to implement a standardized program across the state. Using project management fundamentals, a replicable standardized approach was developed to assure consistency of operation and streamlined implementation. This process, now called the CTRC Program Developer, provides a simple step by step approach to telehealth development and implementation.

This approach has been adapted and expanded for use in all types of services settings and applies to both small and large facilities. It provides a roadmap to traveling the road from initial program interest to program implementation and operation. It also incorporates telehealth best practices and resource materials to offer a process customized to the telehealth environment.

The goal of the Program Developer is to allow new programs to learn from the experience of others, to reduce trial and error, and most of all to create successfully operating telemedicine programs. It can easily be adapted and customized to the size and formality of your program.

The Program Developer is a living document that will continue to incorporate new best practices and lessons learned. Materials for the kit are available in print format and online at the CTRC website. We welcome your feedback on using the Program Developer in your program.

California Telehealth Resource Center

© CTRC 2014

The California Telehealth Resource Center (CTRC) and all resources and activities produced or supported by the CTRC are made possible by grant number G22RH30349 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS. This information or content and conclusions are those of the CTRC and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
Introduction and Overview

You want to start your telemedicine program quickly and you don’t want to learn by trial and error. You want to know when you are on track and when you should make adjustments. The CTRC Program Developer was designed to assist you in developing and implementing telehealth services. This Guide provides overview information on the process and the activities and information you will collect during each of the development phases.

Each of the steps is designed to allow your organization to consider critical aspects of development and to support decision making. The phases and steps are shown below:

Assess & Define
Three steps support assessing the environment and defining the proposed program:

Step 1: Assess Service Needs & Environment
- Assess service needs
- Identify potential telehealth opportunities
- Assess organizational readiness

Step 2: Define Program Model
- Consider the type of program that will meet needs

Step 3: Develop Business Case
- Determine the impact of the proposed telehealth program

Develop & Plan
Two steps support fully defining the activities necessary for program implementation:

Step 4: Develop and Plan Program & Technology
- Create a detailed project plan

Step 5: Develop Performance Monitoring Plan
- Define monitoring and evaluation mechanisms and program improvement process

Implement & Monitor
The final two steps support implementation and ongoing monitoring:

Step 6: Implement Telemedicine Program
- Perform all the work required to implement the program

Step 7: Monitor and Improve Program (Ongoing)
The Steps Can Blend Together

Although the CTRC Telehealth Program Developer presents distinct steps, in actual practice the steps blend together into one process. Information from one step may overlap with another step and information obtained in a later step may require reconsideration of an earlier step.

Every Program Is Unique—Customize the Seven Steps For Your Organization

Telemedicine programs vary significantly in their objectives, size, and complexity. And organizations differ in the way they make decisions. Depending on the organization and the way you make decisions, you may need to develop written reports or simply provide an informal presentation. No matter the size of your program, CTRC recommends that you address each of the components in the Program Developer. Experience shows that programs that follow these guidelines, experience fewer setbacks and greater successes.

Why Not Just Start Implementing

“Measure Twice, Cut Once”

You may wonder why we just don’t start with Step Six: Implement the Program. After all, that’s what you intend to do. Experience has shown that the most successful telemedicine programs take the time to carefully identify and define program needs before beginning. A structured development process allows you to consider decisions and impact before making buying and other costly decisions. The danger of starting with Step Six is that you will be required to make decisions without necessary information and many of your decisions will have to be revisited and revised. These decisions are often costly and time consuming.

You may think that Steps One through Five will take a substantial amount of time, but the length of time required depends on the scope and complexity of the project. A small project may be done very rapidly, while a large project should not be done without careful coordination of tasks and stakeholders. Steps One through Five allow you to draw on the extensive experience of others thus avoiding known pitfalls.

These steps also allow you to identify and incorporate best practices into your program during the development, rather than making mistakes and having to rework your program as you go along.
Assess and Define

You’ve got to be careful if you don’t know where you’re going, because you might not get there.
- Yogi Berra

One: Determine Needs
Two: Define & Specify Program Model
Three: Define and Develop Business Case

Assess and Define
Steps One, Two and Three, will determine the clinical and community needs that would be supported through the development of a telehealth program. During Assess and Define, a needs assessment is undertaken to collect quantitative data on service level needs. Based on these needs, the type of telehealth program can be defined and a certain level of specificity can be developed about the telehealth program model. During these initial steps, the business case will be considered to determine how the program fits into the business plan of the organization, what revenue streams it may create, how it may be funded for start-up and operation and what secondary sources of revenue may be created from the telehealth program. This is also the time to fully consider the existing market place to determine if there is a market for a new telehealth program.

The first three steps will:

• Identify and document the need and rationale for the envisioned telemedicine program.

• Define the health care or other services your telemedicine program will deliver.

• Describe how the targeted services will be delivered.

• Perform a market analysis to determine if there is a market for the service you are proposing to provide and a willingness and mechanism to pay for it.

Tabs for steps One, Two and Three provide detailed information on activities related these steps.
Develop and Plan

A plan is a list of actions arranged in whatever sequence is thought likely to achieve an objective.

John Argenti, founder
Strategic Planning Society

Four: Develop Detailed Program & Technology Plan
Five: Develop Performance Monitoring Plan

Develop and Plan

Steps Four and Five are about planning – identifying the work that needs to be done and the steps required to achieve each of the work products. It is easy to think that planning is actually doing the work, but that occurs in Steps Six and Seven. All we want to do now is create detailed plans. In Steps Two and Three of your program development effort, you defined the program model, developed a high-level understanding of what will be required to deliver the targeted services in the proposed way, and developed a business case demonstrating why it makes sense to deliver the targeted services in the proposed way.

In Steps Four and Five you will:

- Use all the information collected in Steps Two and Three to create a plan that details all the areas that require work during the implementation.
- Define all the tasks needed to build, test, deploy, and operate the program.
- Determine who will be needed perform the tasks.
- Estimate the hours required to do the work (effort).
- Estimate the timeline for the work.
- Determine if additional staff are required in certain areas.
- Develop a plan to monitor program performance and evaluate the program.

Tabs for Steps Four and Five contain detailed information on these activities.
Implement and Monitor the Telehealth Program

Have a plan. Follow the plan, and you’ll be surprised how successful you can be.
Most people don’t have a plan.
That’s why it’s is easy to beat most folks.

Paul “Bear” Bryant, football coach
University of Alabama’s Crimson Tide

Six: Implement the Telemedicine Program
Seven: Monitor and Improve the Program

Implement and Monitor
With your plan in hand, you are now ready to implement your telemedicine program. Steps Six and Seven, allow an organization to use the written plans developed in Steps Five and Six to implement the new or expanded program. Because there is a written plan, the implementation team and executive management will be able to fully monitor progress and provide assistance and support if challenges arise. With the written plan, the team can monitor actual efforts to anticipated time, cost and use of resources.

In addition, ongoing monitoring of the program described in Step Seven, uses performance indicators to assess the impact of the program.

During Steps Six and Seven you will:

• Put into action the plans, decisions, and approaches identified in Step Four.

• Begin monitoring the program using the approach identified in Step Five.

Tabs for Step Four and Five contain detailed information on these activities.
Telehealth Program Developer
Step by Step Checklist

This checklist highlights the areas that will help you identify important factors to consider during each of the seven steps. If you answer no or unsure for any question, further work should be done to address the question.

### Assess Service Needs & Environment

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You know what healthcare services are not currently available to your patients.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. You have identified and prioritized activities suited for telehealth.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. You have identified the assumptions and constraints for implementing a telehealth program.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. You have decided on the top reasons for developing a telehealth program, based upon your needs assessment results.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. You have determined that there is willingness and desire to pay for the fulfillment of the need.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### Define and Specify Program Model

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You know which services will be offered to meet the identified patient needs.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. You have identified the mode of service delivery.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. You have determined who will provide the service and where they are located.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. You have identified the organizational model that best suit your patient needs.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. You have identified any constraints based on your organization, for example federally qualified health center rules.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. You know the general technological features &amp; functions that are needed to deliver the target services in the proposed way.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. Of the choices of technology, you have selected the one most appropriate for your program.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. You have identified any additional human resources needed and where will they be located.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. You have identified any additional facility-related resources needed and where will they be located.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10. You have identified any legal, legislative or regulatory constraints that your organization would need to consider when developing your telehealth program.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11. You have determined your program's implementation approach (i.e., phased, pilot).</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
### Develop Business Case

1. You have determined approximate start up and operating costs for your telehealth program.  
   - Yes  
   - No  
   - Unsure  

2. You have determined how the benefits of telehealth relate to the mission of your organization and the needs of the community.  
   - Yes  
   - No  
   - Unsure  

3. You have identified the payer mix.  
   - Yes  
   - No  
   - Unsure  

4. You have obtained financial commitment to implement and sustain your telehealth services.  
   - Yes  
   - No  
   - Unsure  

5. You know the approximate expected cost reductions (e.g., providers who no longer travel to remote clinics).  
   - Yes  
   - No  
   - Unsure  

### Plan Program and Technology

1. You have identified the activities or steps that you will undertake to achieve your telehealth objectives.  
   - Yes  
   - No  
   - Unsure  

2. You have developed a plan that you will need for managing the work involved in establishing a telehealth program.  
   - Yes  
   - No  
   - Unsure  

3. You have identified who in a leadership position in the organization will be involved in your program and what their role will be.  
   - Yes  
   - No  
   - Unsure  

4. You have identified members of your telehealth team and their roles and responsibilities.  
   - Yes  
   - No  
   - Unsure  

5. You have developed a communication/marketing strategy to promote your telehealth services.  
   - Yes  
   - No  
   - Unsure  

6. You have developed policies and procedures for operation of the program.  
   - Yes  
   - No  
   - Unsure  

7. You have a suitable space for telehealth.  
   - Yes  
   - No  
   - Unsure  

8. You have determined how appointments will be scheduled.  
   - Yes  
   - No  
   - Unsure  

9. You have determined how referrals will be made.  
   - Yes  
   - No  
   - Unsure  

10. You have identified the type of training needed and who needs to be trained.  
    - Yes  
    - No  
    - Unsure  

11. You have developed clinical referral guidelines.  
    - Yes  
    - No  
    - Unsure  

12. You have determined how telehealth will be integrated into clinic operations.  
    - Yes  
    - No  
    - Unsure  

13. You have identified the detailed attributes of hardware, software, and telehealth (i.e., bandwidth, product standards, and product features).  
    - Yes  
    - No  
    - Unsure  

14. You have defined the necessary service level and support agreements.  
    - Yes  
    - No  
    - Unsure
15. You have identified the interoperability and scalability requirements.

16. You have identified the existing organizational resources that can be used to meet specified requirements (e.g., existing network, hardware, equipment).

17. You have identified the types of approvals or authorizations required to assign existing resources to the telehealth services.

18. You know the organization’s procurement policies and procedures.

**Develop Performance Monitoring Plan**

1. You have developed an approach to measure, track, and achieve your targets for telehealth volume and utilization.

2. You have developed a plan to measure success in achieving your project goals, objectives and outcomes.

3. You have determined how you will know what impact telehealth has made in your organization.

4. You have identified data collection methods for obtaining the needed data.

5. If the performance objectives are not being met, you have developed a process of identifying and implementing the necessary changes.

6. You have determined how program improvements will be defined, planned, implemented, tested, and managed.

**Implement the Telehealth Program**

1. You are monitoring project schedules and determining if deliverables are being met.

2. You are identifying risks and mitigating when necessary.

3. You have implemented your communication plan.

4. You have determined how needed program modifications are identified and managed.

**Monitor & Improve Program**

1. You can determine if the program is meeting its objectives.

2. You can identify what changes are needed to ensure that the program meets its objectives.
Using This Kit

Successfully building a telehealth program relies on a number of critical skills including technology, clinical, and operational skills as well as program development and, often overlooked, project management skills. The CTRC Program Development Guide has been developed to bring together a project management process designed specifically for telehealth to allow new, operating and expanding programs to easily assess their current position, identify needed activities and actions, and move toward implementation or enhanced service delivery.

This kit contains a variety of materials to assist you

The Program Developer Guide that contains information on the major implementation activities, materials that have been developed to provide detailed information on a variety of telehealth topics, and templates that can be used to produce a variety of reports, worksheets and assessments. All of these materials have been developed using nationally recognized best practices for telehealth.

This Kit contains the Program Developer Guide along with guides and templates that related to these tasks. Also included are a wide variety of general use guides and templates. The CTRC website has additional information that is updated regularly and also provides critical information to support your program development.

Training videos to support these steps are available through the CTRC website - www.caltrc.org

A complete listing of the materials as of this printing is found in the Resources section of the website.

Development Is Not Completely Linear

Although the steps presented here are in sequential order, keep in mind that steps often loop back on each other as more information is obtained. Sometimes you may gather information that is used in an immediate step as well as in a later step. Your development is unique to you; however the seven steps provides a foundation that covers the necessary analysis and decision points.
Guideposts

Throughout this guide you will find icons that are guideposts for action and activity. Each of the Guideposts is shown below:

In a nutshell: Provides a summary of the information in the guide.

Tools: Lists the various tools that will assist during the step

Before you move forward: Experience has shown that certain actions or inactions can seriously impact the quality or timeliness of your development. This guidepost alerts you to consider a critical factor before moving forward.

Get some additional information or direction: Lists or directs you to additional information.
This matrix contains a high level summary of the questions to answer for each of the steps, the products and activities associated with each step, and a listing of CTRC Guides, Video and Tools to support programs development efforts. New materials are released regularly. Check the CTRC website for new products and sign up for our emails to be alerted to new offerings.

### Step 1: Determine Program Need

<table>
<thead>
<tr>
<th>Questions to Answer</th>
<th>Products and Activities</th>
<th>Program Developer Guides / Videos / Tools</th>
</tr>
</thead>
</table>
| • What might telemedicine do for my organization?                                  | • Perform Organization Readiness Assessment  
• Organizational Readiness Assessment Report  
• Approval to Proceed  
• Allocation of resources  
• Perform Needs Assessment  
• Needs Assessment Report                                                          | • Program Developer Guide  
• Assessing Organizational Readiness Guide  
• Organizational Readiness Video  
• Organizational Readiness Assessment Template  
• Organizational Readiness Summary and Approval Template  
• Predictors of Success Video  
• What Is telemedicine Video  
• Typical Visit Video  
• Technology Overview video  
• Telemedicine Applications video  
• Needs Assessment Guide  
• Needs Assessment Template  
• Needs Assessment Video  
• Best Practices for Step One                                                          |
| • Is my organization ready and willing to support telemedicine development?         |                                                                                        |                                                                                                           |
| • What resources need to be allocated for initial planning?                          |                                                                                        |                                                                                                           |
| • What are the unmet healthcare needs of our existing and potential patients?       |                                                                                        |                                                                                                           |
| • Which of these needs may be met using telehealth?                                 |                                                                                        |                                                                                                           |
| • What provider related needs or opportunities might be met with telehealth?       |                                                                                        |                                                                                                           |

### Step 2: Define Your Program Model: Preliminary Definition and Scope

<table>
<thead>
<tr>
<th>Questions to Answer</th>
<th>Products and Activities</th>
<th>Program Developer Guides / Videos / Tools</th>
</tr>
</thead>
</table>
| • What services have you decided to provide?                                      | • Kick Off Meeting  
• Preliminary Program Charter  
• Preliminary Program Proposal  
• Telemedicine Program Model  
• Preliminary Technology Assessment  
• Approval To Proceed  
• Allocation of resources                                                          | • Charter Template  
• Sample Kickoff Meeting Agenda  
• Project team composition checklist  
• Best Practices for Step Two                                                          |
| • How will the services be provided?                                               |                                                                                        |                                                                                                           |
| • What is the proposed scope of the program?                                       |                                                                                        |                                                                                                           |

2014 Edition © CTRC 2014 11
### Step 3: Detailed Analysis of the Program Model: Detailed Analysis: Cost, Service Delivery, Technology and Business Analysis

<table>
<thead>
<tr>
<th>Questions to Answer</th>
<th>Products and Activities</th>
<th>Program Developer Guides / Videos / Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the estimated demand for the service?</td>
<td>Market Analysis</td>
<td>Reimbursement Guide</td>
</tr>
<tr>
<td>What service and technology estimates/assumptions are being used for the cost projections?</td>
<td>Business Case Report</td>
<td>FQHC Reimbursement Guide</td>
</tr>
<tr>
<td>What is the financial model associated with the proposed program?</td>
<td>Clinical Services Requirements and Implementation Approach / Strategy</td>
<td>Telecommunications Discount Guide</td>
</tr>
<tr>
<td>How will the program be funded or supported – initially / ongoing?</td>
<td>Technology Requirements and Implementation Approach / Strategy</td>
<td>FQHC Reimbursement Video</td>
</tr>
<tr>
<td>How will the program impact the organization’s financial position?</td>
<td>Site Readiness Assessment</td>
<td>Market Analysis Video</td>
</tr>
<tr>
<td>Is the program sustainable?</td>
<td>Updated Program Charter</td>
<td>Marketing Guide</td>
</tr>
<tr>
<td>Will the program create revenue in another area of the organization?</td>
<td>Approval To Proceed</td>
<td>Marketing Templates</td>
</tr>
<tr>
<td>Will the program require subsidy from the organization?</td>
<td>Staff plan</td>
<td>Sample Consent Form</td>
</tr>
<tr>
<td>Is there a demonstrated return on investment?</td>
<td></td>
<td>Provider selection template</td>
</tr>
<tr>
<td>What are the clinical program requirements?</td>
<td></td>
<td>Roles and Responsibilities Video</td>
</tr>
<tr>
<td>What are the operational program requirements?</td>
<td></td>
<td>Roles and Responsibilities Guide</td>
</tr>
<tr>
<td>What are the technology requirements?</td>
<td></td>
<td>Technology Guide</td>
</tr>
<tr>
<td>How will the technology requirements be met?</td>
<td></td>
<td>Site Readiness Assessment Worksheet</td>
</tr>
<tr>
<td>What implementation approach will be used?</td>
<td></td>
<td>Best Practices for Step Three</td>
</tr>
</tbody>
</table>
### Step 4: Create A Detailed Plan: Add the Specifics

<table>
<thead>
<tr>
<th>Questions to Answer</th>
<th>Products and Activities</th>
<th>Program Developer Guides / Videos / Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What are the tasks needed to implement the program?</td>
<td>• Clinical Services Implementation Plan</td>
<td>• Training Guide</td>
</tr>
<tr>
<td>• Clinical Services</td>
<td>• Technology Implementation Plan</td>
<td>• Training Templates</td>
</tr>
<tr>
<td>• Operational</td>
<td>• Communication Plan</td>
<td>• Competency skills template</td>
</tr>
<tr>
<td>• Technology</td>
<td>• Budget</td>
<td>• Sample Duty Statements</td>
</tr>
<tr>
<td>• Human Resources</td>
<td></td>
<td>• Room Design Guide</td>
</tr>
<tr>
<td>• Physical Environment</td>
<td></td>
<td>• Best Practices for Step Four</td>
</tr>
<tr>
<td>• What are possible challenges and how will we handle problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• How will the work be organized?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• How will we communicate with stakeholders?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Step 5: Develop Performance Monitoring Plan

<table>
<thead>
<tr>
<th>Questions to Answer</th>
<th>Products and Activities</th>
<th>Program Developer Guides / Videos / Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How will overall program performance be monitored and assessed?</td>
<td>• Program Monitoring Plan</td>
<td>• Performance Indicators and Data Elements Matrix</td>
</tr>
<tr>
<td>• What data will be need to be collected?</td>
<td>• Quality Improvement Process</td>
<td>• Best Practices for Step Five</td>
</tr>
<tr>
<td>• How will the data be collected?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• How will program modifications and modifications be identified and implemented?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Step 6: Manage the Implementation of the Program

<table>
<thead>
<tr>
<th>Questions to Answer</th>
<th>Products and Activities</th>
<th>Program Developer Guides / Videos / Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Are project schedules being met?</td>
<td>• Project Management Reports</td>
<td>• Sample Clinical Protocols</td>
</tr>
<tr>
<td>• Are risks being identified and mitigated?</td>
<td>• Program deliverables</td>
<td>• Video Etiquette/Procedures</td>
</tr>
<tr>
<td>• Is a communication plan in place?</td>
<td></td>
<td>• Completion Checklist</td>
</tr>
<tr>
<td>• Is work being done in a quality manner?</td>
<td></td>
<td>• Patient Informing and Consent Materials</td>
</tr>
<tr>
<td>• Do any tasks need revision?</td>
<td></td>
<td>• Best Practices for Step Six</td>
</tr>
<tr>
<td>• Are any needed program modifications being identified and managed?</td>
<td></td>
<td>• Dermatology Guide</td>
</tr>
<tr>
<td>• Is the program ready for operation?</td>
<td></td>
<td>• Diabetic Retinopathy Guide</td>
</tr>
</tbody>
</table>
Step 7: Begin Service; Ongoing Program Monitoring and Improvement

<table>
<thead>
<tr>
<th>Questions to Answer</th>
<th>Products and Activities</th>
<th>Program Developer Guides / Videos / Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the program meeting its objectives?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What program changes would ensure that the program meets its objectives?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What challenges or improvements have been identified?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Data analysis reports and/or presentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Improvement logs and data collection documents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implemented improvements and changes to the program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patient Satisfaction Survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Best Practices for Step Seven</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Step One

Assess Service Needs & Environment

<table>
<thead>
<tr>
<th>Questions to Answer</th>
<th>Products and Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What are the unmet healthcare needs of our existing and potential patients?</td>
<td>• Needs Analysis &amp; Report</td>
</tr>
<tr>
<td>• Which of these needs may be met using telehealth?</td>
<td>• Organizational Readiness Assessment &amp; Report</td>
</tr>
<tr>
<td>• What provider related needs or opportunities might be met with telehealth?</td>
<td>• Preliminary Technology Assessment &amp; Report</td>
</tr>
<tr>
<td>• Are there any major organizational barriers that should be addressed before</td>
<td>• Learn about telehealth</td>
</tr>
<tr>
<td>starting development?</td>
<td>• Engage stakeholders</td>
</tr>
<tr>
<td>• Is telehealth in line with your organization’s mission and strategic plan?</td>
<td>• Read the CTRC Best Practices Guide</td>
</tr>
</tbody>
</table>

Telehealth programs usually get started because there are unmet healthcare needs that might be addressed by providing telehealth – technology enabled healthcare from a distance. Perhaps your community needs medical specialty services or clinicians need more access to continuing education. Perhaps you have heard that home monitoring of chronic disease patients reduces hospital and emergency department admissions. Telehealth has many applications and uses, so a first task is to determine what your community needs and how telehealth could address those needs.

In the initial step of program development you will explore telehealth, identify service needs that might best be met with a telehealth application, and take a look at your organization to assess if there are any barriers that might hinder successful implementation.

It is often useful to bring a team together early in the assessment process to assure that all stakeholders are involved in performing the research and developing recommendations about the program.

In a nutshell: During Step One you will:

- Identify and assess unmet clinical, educational or administrative needs
- Assess your organizational readiness
- Perform a preliminary technology assessment
- Identify potential telehealth opportunities
- Learn about telemedicine technology applications
- Learn about predictors of success and best practices
- Begin to engage stakeholders - bring a team together
Activities

1. Assess Organizational Readiness

Knowing if your organization is ready to take on the challenges and embrace the opportunities of implementing a telemedicine program is an essential component of Step One. The best time to assess readiness is before you begin development and implementation. Identifying any serious barriers early will allow opportunity to address before the project is impacted.

Tools for this Activity:
- Organizational Readiness Assessment - Video
- Organizational Readiness Assessment - Guide
- Organizational Readiness Assessment - Template
- Organizational Readiness Assessment – Summary of Results

2. Analyze Needs: Identify & assess unmet clinical, educational and administrative needs

This step may seem simple but the success of your program will, to some extent, depend on the research and effort you have placed on really identifying unmet needs. It is easy enough to say “we need dermatology” but successful programs go further and identify what level of service is needed and why it is a current need. Whether you are a large health system developing a provider network or a single rural health clinic, an analysis of need of the population you intent to serve with telehealth is necessary.

In a nutshell: Determine the current capacity to provide services and the current need for those services. Don’t rely completely on perceived needs. Collect data. It will be important as you develop your service.
First, decide on the scope or extent of your analysis. Will your analysis focus on the patients and providers in your clinic or will it look at needs within the community that are currently not being addressed.

Second, decide what data you will collect, where this data might exist, and how you will get the data. Billing records, referral records, surveys and interviews with clinicians and patients, public health data, needs assessments of other agencies, interviews with community leaders are all great ways to collect information. The idea is to find out what is needed and then to quantify this need so you can create measurable program goals and objectives. This analysis also assures that there is an adequate need for services before you make decisions about the program design and model.

Third, determine what your current services are, what you want them to be and the difference between the two – it’s often called the gap or a gap analysis.

Fourth, prioritize the needs – there may be more needs or opportunities to use telehealth than you think you can start all at once.

Fifth, identify any major barriers that would impact the ability to move forward with the needed services.

Tools for this Activity:
- Needs Assessment - Guide
- Needs Assessment - Worksheet

3. Preliminary Technology Assessment

You and your IT staff will want to do an initial assessment of your connectivity and network so you can determine if there are major barriers or improvements that will be needed as you look at the type of services you would like to provide.

Put It In Writing!

Even if the needs analysis is not a highly detailed or formal report, it is strongly recommended that the results be developed into a written format. Later in the development you will need to review your original assumptions and decisions.
4. Learn about telehealth

This is a great time to begin learning about telehealth – how it works, different applications, what equipment is used, what resources are available – everything and anything. This kit and the CTRC website have short videos on many introductory topics as well as reference guides in many areas. Many other websites and organizations have great information as well. CTRC staff can help you find resources for your areas of interest.

This is also a good time to consider attending a training program, enrolling in an online program or bringing some training to your organization.

5. Read the Best Practices

The Best Practices Tab has a compendium of lessons learned by other telehealth programs which can be most helpful to you during development.

Tools for this activity
Best Practices Compendium - See Best Practices Section
Have you covered everything?

Take a look at the Step One Checklist. You may see some things to consider before you move on.

Assess Service Needs and Environment Checklist

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You know what healthcare services are not currently available to patients.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. You have identified and prioritized activities suited for telehealth.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. You have identified the assumptions and constraints for implementing a telehealth program.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. You have decided on the top reasons for developing a telehealth program, based upon your needs assessment results.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. You have determined that there is willingness and desire to pay for the fulfillment of the need.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Organizational Readiness Tools

The following tools may be of assistance in performing an organizational readiness assessment:

1. The *Organizational Readiness Guide* that will assist you in looking at key factors for successful program initiation.

2. The *Organizational Readiness Assessment Template* has the questions you want to answer to determine if your organization is ready to begin telehealth development.

3. The *Organizational Readiness Assessment Summary* transfers the answers from the Assessment template to a summary document that can be used to present your findings to an oversight or governance body.
Assessing Organizational Readiness
Is Your Organization Ready for Telehealth?

Determining organizational readiness is an initial step an organization should take to assure that a new telehealth program will be fully adopted and utilized.

Telehealth offers healthcare organizations new and effective systems for delivering healthcare and, in many instances, allows organizations to reach far beyond current service offerings and think creatively about delivery models. Implementing a telehealth program is an organizational change, and like all change it’s about people. Technology is a cornerstone of telehealth programs; however, successfull implementation requires the ability to manage change.

Telehealth programs don’t always begin as a result of an organization’s strategic planning process. In many cases, an individual within the organization takes an interest in telehealth and begins to promote that idea to others. Ideally, an organization embraces telehealth and makes optimal use of the technologies, but unfortunately there are programs that did not adequately or accurately assess the current position of the organization prior to starting a telehealth program and as a result end up with expensive equipment sitting idle in a closet.

How do you know if your organization is ready to take on the challenges and embrace the opportunities of implementing a telehealth program? The best time to assess an organization’s readiness for change is before you begin implementation. The importance of assessing your organization’s readiness for change cannot be underestimated.

What exactly is organizational readiness and why is it important?

Organizational readiness – the willingness and ability of an organization to shift from its current way of operating.

Organizational readiness is becoming aware of the current state of an organization in the context of going somewhere new. Organizations that successfully implement a telehealth program have the internal ability and willingness to move in a new direction. Willingness focuses on the desire of the organization and its employees to change and embrace new ways of working. Ability focuses on having or acquiring the skill sets necessary to successfully implement a change. Assessing organizational readiness will identify any major challenges that could delay or prevent your new program’s successful start-up. Organizational strengths can be leveraged to assist in program development and acceptance.

Experts estimate that 50 percent of all change efforts fail because leaders do not sufficiently assess organizational readiness for change.
Performing a Readiness Assessment

Performing an evaluation of organizational readiness does not have to be time consuming, and in many cases can be easily accomplished in a day. This assessment may be as simple as reviewing the steps in the guide to assure that critical areas have been considered or as detailed as a written presentation for executive management. The level of formality depends on your organization’s needs and culture. No matter how extensive the review, the assessment or organizational readiness is a critical component of a successful telehealth program.

Describe the desired program and how it would change the existing organization.

The first task in assessing organizational readiness is to identify the desired new program. Develop a short paragraph that specifically describes the action or program that the organization is considering. While this may seem rather basic, it will assure that all stakeholders have the same vision.

Some examples might be:
- For a clinic: Implement a telehealth program that allows medical specialty services to be provided at a clinic using remote specialists.
- For a hospital: Implement a telestroke program that provides telehealth neurology consults for emergency department patients experiencing stroke symptoms.
- For a provider: Expand the existing practice to provide dermatology services to new and existing patients.

Determine how the proposed project would align with the Current Organization.

The second task in assessing organizational readiness is to determine how the existing state of the organization relates to the desired new program. It is desirable to assess the alignment of the proposed project with the organization’s current vision, mission, and strategic plan. Consider the following questions to determine your organization’s readiness to take on the proposed new program.

1. Does the proposed project align with the organization’s current vision, mission, and strategic plan?
   - Does the project support the organization’s vision of its desired future?
   - Does the project align itself with the organization’s belief of who it is, what it does, and how it serves?
   - Does the project support the organization’s approach to achieving its goals and objectives?
2. Is the proposed project consistent with the organization’s values and culture?
   - Is the project consistent with the organization’s guiding principles?
   - Does the project align with the organization’s existing beliefs, assumptions, and expectations?
   - Does the organization’s culture support innovation and clinical technology applications?

3. Are resources available to begin development of the proposed project?
   - Is funding available for the initial planning activities?
   - Is there staff available to work on the project?
   - Are there leadership groups in place to foster support?

4. Does the proposed program have a champion?
   - Is there a clinical champion for the project?
   - Is there an administrative champion for the project?
   - Are there leadership groups in place to foster support?

5. Do stakeholders support the program?
   - What perceptions do stakeholders have about the proposed program?
   - Are stakeholders educated about the proposed program?

6. Who has authority over the proposed program?
   - Who has to approve the project?
   - Are they supportive of the project?

7. Are there potential opportunities or barriers to initiating the program?

   A SWOT Analysis can be beneficial in assessing organizational readiness for implementing a new program. SWOT identifies an organization’s strengths and weaknesses and may identify any areas that need change in order to move forward. It identified opportunities that will contribute to success and the treats or barriers that may inhibit success.
   - What are the organization’s strengths?
   - What are the organization’s challenges or weaknesses?
   - Where are the organization’s business opportunities?
   - Are there any barriers to the organization’s success?

8. Is your organization technology ready?

   Performing a preliminary technology assessment can assist in identifying barriers to program success.
TECHNICAL NEEDS ASSESSMENT

Do you have internet access in your clinic exam rooms?*

- All Rooms
- Some Rooms
- Via Wall Jack
- Via Wireless

Do you have internet access in the room you use for conferences and staff meetings?*

- All Rooms
- Some Rooms
- Via Wall Jack
- Via Wireless

Do you receive your broadband from the California Telehealth Network (CTN)?*

- All Rooms
- Some Rooms
- Via Wall Jack
- Via Wireless

If you currently have telemedicine equipment at your facility, please specify below:*

☐ Live Video
☐ Store and Forward
☐ No Equipment

VIDEO EQUIPMENT SPECS

Video conferencing equipment type: ________________________________

Is your unit high definition or standard? ________________________________

Monitor Size: __________ Is the unit wall mounted or on a mobile cart? __________

Can it easily be moved from one room to another?  ☐ Yes  ☐ No

Do you have peripheral equipment that is to be used with the unit? (ex: Dermscope, Otoscope, Stethoscope) If so, please list all: ________________________________

STORE AND FORWARD

What Specialties Do You Utilize? ________________________________

Software Used? ________________________________ Camera Used? ________________________________

Do you have an EHR?  ☐ Yes  ☐ No  ☐ Implementing Currently

Please list the brand: ________________________________
After the Assessment: Summarize findings, address possible challenges or deficiencies, obtain support and approval.

Answering the questions above will give you a good idea about whether your organization is fully ready to undertake a new program implementation. If not fully ready, the assessment will give you a clear picture of what specific areas require attention before proceeding, such as obtaining support from stakeholder groups. After making any necessary organizational adjustments or changes, reviewing the assessment worksheets again will help ensure that you are ready to move forward.

When there is agreement that the organization is ready to move forward, a structured program development process can be extremely beneficial in keeping your implementation on track with a minimum of problems.
Needs Analysis Tools

The following tools that may be of assistance in performing a needs analysis.

1. *The Needs Assessment – Areas to Consider and Data Sources*, contains a variety of questions that might be pertinent to your needs analysis and suggests some possible data sources.

2. *The Guide To Performing A Formal Needs Assessment*, provides details on the tasks involved in creating a large scale needs assessment. Some organizations might require this level of discovery and analysis. It can be simplified as described in Step One for smaller studies. The information, however; can be very useful to consider.

3. *The Organizational Readiness Assessment Template* is a template that contains key questions to consider as you analyze your unmet needs and space for you to document any thoughts or answers.
Needs Assessment

There are many ways to collect data on community needs and resources. Provided below are sample data that may be collected in determining your community needs and identifying services that may be provided via telehealth. Also included are suggestions on how to locate the data for each of the data collection recommendations. Please keep in mind that this is not an exhaustive list, and it should be modified or adopted to meet your organizational needs.

Demographic and Socioeconomic

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Possible Data Sources</th>
</tr>
</thead>
</table>
| Age Analysis: Compare the county and state percentage age distributions and describe how the county age distribution is different from the state. | 1. CDC National Center for Health Statistics http://www.cdc.gov/nchs/  
3. State health department |
| Race/Ethnicity Analysis: Compare county and state distributions and describe how the county distribution is different from the state? Do you have any racial/ethnic group needing special consideration? | 1. CDC National Center for Health Statistics http://www.cdc.gov/nchs/  
3. State health department |
| Socio-Cultural-Demographic Features: Identify any unique features of your county that may increase risks of health problems for members of your community (i.e. poverty, high unemployment). | 1. US Census Bureau http://quickfacts.census.gov/qfd/index.html  
2. State health department |

Health Status

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Possible Data Sources</th>
</tr>
</thead>
</table>
| How does your county compare with the rest of the state on chronic disease indicators?  
• Coronary Heart Disease Mortality Rate  
• Cerebrovascular Disease Mortality Rate  
• Hospitalization Rate for Diabetes  
• Hospitalization Rate for Asthma | 1. CDC Data and Statistics http://www.cdc.gov/DataStatistics/  
2. CDC Behavioral Risk Factor surveillance Survey http://www.cdc.gov/brfss/index.htm  
3. State Health Department |
| What is the percent of the population with behavioral risk factors?  
• Cigarette smoking  
• Hypertension  
• Hypercholesterolemia  
• Diabetes mellitus  
• Physical activity  
• Family history of hypertension  
• Family history of hypercholesterolemia  
• Family history of diabetes mellitus | 1. CDC Data and Statistics http://www.cdc.gov/DataStatistics/  
2. CDC Behavioral Risk Factor surveillance Survey http://www.cdc.gov/brfss/index.htm  
3. State Health Department |
| Are there any special populations with chronic disease problems (i.e. race, migrant workers)? | CDC Data and Statistics  
http://www.cdc.gov/DataStatistics/  
CDC Behavioral Risk Factor Surveillance Survey  
http://www.cdc.gov/brfss/index.htm  
State Health Department |
| What conditions drive your re-admission rates? | Review your hospital/clinic re-admission records to identify those conditions that patients are most commonly readmitted for. |
| Are there any diseases or diagnoses that you have found to be particularly difficult to manage locally? | Review your hospital/clinic service data to identify diseases or diagnoses that are commonly referred out to other sites for service provision |

### Service Availability

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Possible Data Sources</th>
</tr>
</thead>
</table>
| Are there any special problems your community faces that restrict access to care (i.e. location, hours of operation, and lengthy wait for next appointment)? | 1. Survey community members to identify any restrictions to access to care at your site.  
2. Facilitate focus group interviews with community members to identify any restrictions to access to care at your site.  
3. Review your hospital/clinic scheduling records to identify services that have longer wait times for the next available appointment. |
| What percentage of your population lacks health insurance coverage? | 1. State health department  
2. US Census Bureau  
http://quickfacts.census.gov/qfd/index.html  
3. Medicare and Medicaid reports |
| What specialty services are needed but not available in your community? | 1. Review your hospital/clinic service data to identify clinical services are available and not available at your site.  
2. Review your hospital/clinic referral records to identify services that are regularly transported out.  
3. Review health status data collected to determine additional services that may be needed in your community.  
4. Survey your target population to identify services they need, but are not available. |
| Are there any populations not served by language-specific or culturally knowledgeable service providers? | 1. Review county demographic information to identify specific populations located in your service area.  
2. Review your hospital/clinic records to identify those populations that are in your service area, but not served by language-specific or culturally knowledgeable service providers |
Are there any gaps between healthcare service needs and available resources?

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Possible Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compare identified healthcare service needs to your community’s available resources.</td>
<td></td>
</tr>
<tr>
<td>• Service needs can be identified through review of hospital/clinic service records, referral records, demographic and socio-economic data, and feedback received from patients or others in the community.</td>
<td></td>
</tr>
<tr>
<td>• Available resources can be identified through asset mapping – identification of local resources in the community.</td>
<td></td>
</tr>
</tbody>
</table>

Where does the demand for healthcare services regularly exceed local resources?

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Possible Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review your hospital/clinic referral patterns to identify services that are regularly referred out to other sites or regularly referred to your site.</td>
<td></td>
</tr>
<tr>
<td>Review your hospital/clinic scheduling patterns to identify services that have long wait times for seeing the provider (helps to determine any provider shortages).</td>
<td></td>
</tr>
<tr>
<td>Review your hospital/clinic scheduling patterns to identify types of services scheduled.</td>
<td></td>
</tr>
</tbody>
</table>

Referral Patterns

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Possible Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are your predominant referral patterns?</td>
<td>• Review your hospital/clinic referral patterns to identify the type of services that are regularly referred out to other sites or referred to your site.</td>
</tr>
<tr>
<td>• Identify where the services are referred to or from and why they are referred (service is not available at all at your site; service is available, but no appointments are available in the near future; service is not available at a distant patient site).</td>
<td></td>
</tr>
<tr>
<td>• Review your hospital/clinic scheduling patterns to identify services that have long wait times for seeing the provider (helps to determine any provider shortages).</td>
<td></td>
</tr>
<tr>
<td>• Review your hospital/clinic scheduling patterns to identify types of services scheduled.</td>
<td></td>
</tr>
</tbody>
</table>

Do you currently refer patients to other sites?

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Possible Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review your hospital/clinic referral patterns to identify the type of services that are regularly referred out to other sites and how often referral are made for each service.</td>
<td></td>
</tr>
</tbody>
</table>

What diagnoses/healthcare services are commonly referred or transported out?

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Possible Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review your hospital/clinic referral patterns to identify the type of services that are most commonly referred out to other sites.</td>
<td></td>
</tr>
</tbody>
</table>
Does your organization have existing referral relationships with distant sites or specialty services?

- Review your hospital/clinic referral patterns to identify the type of services that are regularly referred out to other sites and how often referral are made for each service.

What diagnoses/healthcare services are commonly referred or transported out?

- Review your hospital/clinic referral patterns to identify the type of services that are most commonly referred out to other sites.
- Survey community members to identify where they go to receive healthcare services that are not available locally.
- Facilitate focus group interviews with community members to identify where they go to received healthcare services that are not available locally.

Are healthcare providers in your organization currently traveling to other communities/organizations to provide care?

- Review your hospital/clinic referral patterns to identify the type of services that are regularly referred to your site.

Are healthcare providers in your organization currently traveling to other communities/organizations to provide care?

- Review your hospital/clinic service data to identify services that require healthcare providers in your organization to travel to a different location to provide care.

Are there healthcare providers traveling to your organization from another community/organization to provide care to patients?

- Review your hospital/clinic service data to identify services that require a healthcare provider from another site to provide care to patients in your service area.

Administrative/Educational Events

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Possible Data Sources</th>
</tr>
</thead>
</table>
| Are there any educational events that currently involve travel time and expense, but do not require in-person attendance? | • Review the schedule of educational events attended by staff at your site to determine if any involve travel, but do not require in person attendance.  
• Survey staff to gather additional data on educational events that involve travel, but do not require in-person attendance. |
| Is there an interest in accessing educational events (ground rounds/CME) offered at other sites that have videoconferencing capabilities? | • Survey staff to determine if there is an interest in access educational events offered at other sites. |
| Are there meetings and events that currently take place at your organization that involve travel to another location, but do not require in-person attendance? | • Review the schedule of meetings and events that take place at your organization that involve travel to another location, but do not require in-person attendance.  
• Survey staff to gather additional data on meetings and events that involve travel, but do not require in-person attendance. |
## Payer Mix

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Possible Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many unique patient visits does your site receive per year?</td>
<td>• Review your hospital/clinic service data to identify the number of patients served.</td>
</tr>
<tr>
<td>What is the payer breakdown for those visits?</td>
<td>• Review your hospital/clinic billing data to identify the payer mix for the patients your site serves.</td>
</tr>
<tr>
<td>• Medicare</td>
<td></td>
</tr>
<tr>
<td>• Medi-Cal</td>
<td></td>
</tr>
<tr>
<td>• Commercial/Private Payer</td>
<td></td>
</tr>
<tr>
<td>• CMSP</td>
<td></td>
</tr>
<tr>
<td>• Self pay</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>What is the Medicaid spending by county for the region you serve?</td>
<td>• State Health Department</td>
</tr>
<tr>
<td>• Medicaid reports</td>
<td></td>
</tr>
<tr>
<td>What is the Medicare spending by county for the region you serve?</td>
<td>• State Health Department</td>
</tr>
<tr>
<td>• Medicare reports</td>
<td></td>
</tr>
</tbody>
</table>
Guide to Performing A Formal Needs Assessment

Introduction

When rolling out telehealth programs to deliver healthcare at a distance, it is particularly tempting to begin development efforts by looking at the newest telehealth equipment and deciding to implement a program. However, for best results, you should first conduct a needs assessment.

What is a Needs Assessment?

A needs assessment is a process used to identify the health care needs of a community. Needs assessments collect and analyze data to determine the current level of service availability, the desired level of service availability and the gap between the two. With data driven need identification, your organization’s clinical, executive, administrative, and other key stakeholders are better able to evaluate the rationale for developing the envisioned telemedicine program. A needs assessment can be summarized in a single page or in a volume depending upon your requirements and resources.

Conducting a needs assessment provides many benefits, including:

- Clear understanding of community need
- A foundation for program development
- Clear objectives and shared expectations among stakeholders
- Improved coordination of services and rational allocation of resources
- The ability to evaluate program effectiveness
- Information for the marketing analysis and business plan

The needs analysis, market analysis, and business model development are interrelated activities. Organizations may wish to combine needs assessment, market research, and analysis activities.
There are many ways to conduct a needs assessment. For simplicity, we are providing one framework that you may adapt. The size and scope of your envisioned telemedicine program will determine how formal or comprehensive your needs assessment will be.

Don’t worry if you get part way through and find yourself amending previous activities. This is not a linear process. It is as interactive and dynamic as your services are likely to be.

The following table summarizes the activities of a needs assessment.

### Needs Assessment Summary

<table>
<thead>
<tr>
<th>Steps</th>
<th>Activities</th>
<th>Using this step you will</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define the Scope</td>
<td>Identify your assessment’s scope</td>
<td>Determine how much of the community’s unmet needs you can handle. Are you going to limit your analysis to some specific telemedicine application area or some targeted illness or a particular geographic location?</td>
</tr>
<tr>
<td>Data Collection</td>
<td>Identify your assessment approach</td>
<td>Identify what information you will consider to establish possible needs and opportunities. Consider what analysis methods will be used and, if looking at new information, determine how data will be collected. Who will do this work?</td>
</tr>
<tr>
<td>Gap Analysis</td>
<td>Identify your current and desired states</td>
<td>Describe the current patient, health care services, and provider environment (i.e. what your organization does now) and identify the new or augmented patient, health care services, and provider environment that will be supported by telemedicine programs (i.e. what you want to do) in the future.</td>
</tr>
<tr>
<td></td>
<td>Identify the Gap</td>
<td>Define the difference between what you currently do and what you envision doing. Explain what is needed to bridge the “gap” by describing all new or expanded clinical services, the anticipated telemedicine delivery model and high-level technology, provider and other requirements.</td>
</tr>
<tr>
<td>Potential Barriers</td>
<td>Identify barriers</td>
<td>Describe obstacles and challenges to achieving the desired state. What additional steps you must take to achieve your objectives? Can you take those steps?</td>
</tr>
<tr>
<td>Services Priorities</td>
<td>Assign priorities</td>
<td>Rank the new or expanded clinical services and other objectives in priority order. If subsequent analysis or occurrences determine it is not feasible to implement all services or it is not feasible to implement all at once, the priorities will help identify which services to pursue.</td>
</tr>
<tr>
<td>Next Steps</td>
<td>Summarize and present results</td>
<td>Pull together the results of your needs assessment and present them to key stakeholders. Seek permission or buy-in for continuing with the program development effort.</td>
</tr>
</tbody>
</table>
**Task 1: Defining the Scope**

The initial task in the needs assessment process is to define the scope. In most cases it is done to determine how telemedicine might best meet the unmet needs of the community.

**Questions to consider during this step include:**

- Whose needs will be assessed? Some or all of the existing patient population? Some or all of a projected (potential) new patient population? Providers (e.g., continuing education requirements)? Some or all of your organization (e.g., main hospital and clinics)?

- Which types of healthcare services will be evaluated? Primary care? Specific types of specialty care?

- How extensive will the needs assessment be?

- What kind of resources will be available to conduct the needs assessment?

**Task 2: Identify Assessment Approach**

In this task, you will identify how you will structure and conduct your assessment. Your approach should describe your preliminary assumptions about what specific information you will consider and how you will gather it.

Information, or data, will be at the heart of your needs assessment. You may gather new data to consider in your analysis and you may need to also look at information previously gathered by others.

Provided in the table below is an overview of the major sources of information that may contribute to your needs assessment activities.

---

### Sources of Information

<table>
<thead>
<tr>
<th>Class</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary data</td>
<td>Original or new data that you expect to collect and analyze in the course of your assessment. Examples of primary data include: results from patient surveys; notes from a focus group conducted to gather information on needed healthcare services; etc.</td>
</tr>
<tr>
<td>Secondary data</td>
<td>Information that has already been collected which you can analyze or reference in your needs assessment. Secondary data can exist in previously analyzed form or raw data form (that you can do additional analysis upon). Examples of secondary data would include the health history information the hospital maintains on its clients.</td>
</tr>
<tr>
<td>Qualitative data</td>
<td>Information or facts presented in a narrative format and that generally cannot be presented numerically and cannot serve as the basis for statistical analysis. Interview data is an example of qualitative data.</td>
</tr>
<tr>
<td>Quantitative data</td>
<td>Information presented in numerical terms and that can serve as the basis for some statistical analysis. An example would be results of a survey where respondents can only select from among a fixed set of responses.</td>
</tr>
</tbody>
</table>
Questions to help establish your needs assessment approach:

- What existing (secondary) information is available?
- What new information (primary data) is needed? Where and how will you gather that information?
- How will the needs assessment process be coordinated and monitored?
- How will data be analyzed?
- When, how, and in what form will results be presented?
- Who will do this research?

Data Gathering Tools
Assessment tools commonly used to gather the information for a needs assessment include:

- Focus group interview -- Qualitative method of conducting in-depth interviews with a small number of people whose discussion is planned and facilitated by a moderator.
- Public issues forum – Qualitative method of collecting information from large groups of community members.
- Secondary data analysis – Pre-existing information that is collected without having direct contact with the subject of the research.
- Survey – Quantitative method involving data collection from a sample of individuals selected from a target population.
- Individual interviews – A conversation designed to help gather information about a person’s assumptions/perceptions.
- Asset mapping – Cataloguing local assets/resources to meet organizational or community objectives.

Task 3: Identify Current and Desired State
During this task you define how the organization currently performs, and then how you desire it to perform. Your current state evaluation will generally focus on the healthcare services your organization currently provides along with how the provided services are delivered, the numbers and types of providers, and other characteristics of support services, staff, and equipment. The desired state evaluation will identify the supplemental services, delivery capability, providers and other resources that can be supported by telemedicine.

Questions to help generate ideas about the current and desired states include:

- What types of healthcare services are offered by the organization; where, how and when are those services delivered?
- What healthcare services require residents of your region to travel? Which of these services are amenable to being delivered via telemedicine?
• Are there problems or deficiencies in the availability of or access to specific types of health-care services?
• Are there problems you expect to arise in the future due to changes within your organization, your community, the healthcare industry, the economy (e.g., new competition? downsizing)?
• Could you gain a competitive edge or expand the scope of your organization’s business by providing new or expanded services or by reaching new clients? How might a telemedicine program help you to take advantage of identified opportunities?
• How might you use telemedicine to leverage the strengths of your organization or region? For instance, if your hospital offers premier cardiac care, how might telemedicine help you build upon that strength?
• Is there a market for the proposed service? Are there willingness, desire, and the means to pay for the service?

Task 4: Identify the Gap
In this task, the difference -- or gap -- between the current state and the desired state is described and measured. Here is where you identify the requirements that must be met. A telemedicine gap analysis identifies:

• The new or extended healthcare services that must be provided in order to reach the desired state.
• How the new or extended services will be delivered using a telemedicine model.

It may be appropriate for you to identify specific resources and to confirm their availability/ willingness to participate in the manner envisioned within the proposed telemedicine program (e.g., a specific clinic, hospital or physician).

The gap analysis should identify general technology requirements, not specific equipment models or vendors. Typically clinical and information technology staff will collaborate in order to identify the general technology requirements. For instance, if a new or revised health service will provide secondary cardiology care to remote patients, the gap analysis might state that technology must support: “live” interactive cardiology consult; the ability to measure blood pressure, pulse rate, and body weight in the patient’s home; the capability to perform EKGs and portable x-rays at the client home or a remote client site and store; or the means to forward the results and images. From these requirements, information technology staff can establish general telecommunication and network requirements.

Task 5: Identify Barriers
Once you have identified needed services and whether telehealth could be an appropriate solution, the next task is to identify potential barriers to implementing the healthcare services via telemedicine. Examples of barriers you might identify include:

• Financing (lack of capital, budget constraint, etc.)
• Lack of personnel
• Lack of particular skills
• Lack of equipment and/or peripheral devices
• Inadequate telecommunications and IT infrastructure
• Lack of knowledge of the implementation process
• Inadequate IT support

Identifying barriers may result in specifying additional requirements or recognizing that the desired state must be revised.

**Task 6: Summarize Results**

The next task is to rank the telemedicine program components and the associated requirements in priority order. Which among the proposed services are the most important for your organization to provide? For each of the highest priority services identified, what are the essential elements of the service that must be supported.

Priority ranking provides important information. If later analysis or emerging financial, business or other factors determine that the envisioned program cannot be implemented in its entirety or must be implemented in phases over time, the priorities assigned in this step will help determine what parts of the program should be implemented and when.

**Task 7: Present Results**

The outcome of each task of your needs assessment should be documented in a format that pulls together all of the information obtained during the needs assessment.

If formal approval of the needs assessment is required prior to proceeding to the next phase of developing your telemedicine program, this presentation provides the opportunity for securing this approval. At a minimum, the presentation provides an opportunity to explain the rationale for the envisioned telemedicine program and to solicit stakeholder support and buy-in. We recommend that you secure organizational support and buy-in at the end of each program development phase.
Telehealth Program Developer

Organizational Readiness Assessment Template

Identify the Anticipated or Desired Change

Write Your Program Description and how it will accomplish the desired change:

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Determine how the proposed project would align with the Current Organization

1. Does the proposed project align with the organization’s current vision, mission, and strategic plan?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Minimal Change Needed</th>
<th>Significant Changes Needed</th>
<th>Major Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aligns with Vision / Mission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aligns with Strategic Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Actions Required to Become Fully Ready / Comments:

<table>
<thead>
<tr>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
2. **Is the proposed project consistent with the organization’s values and culture?**

Alignment with Organizational Values & Culture

<table>
<thead>
<tr>
<th>Yes</th>
<th>Minimal Change Needed</th>
<th>Significant Changes Needed</th>
<th>Major Barrier</th>
</tr>
</thead>
</table>

Actions Required to Become Fully Ready / Comments:

---

3. **Are resources available to begin development of the proposed project?**

Resource Availability

<table>
<thead>
<tr>
<th>Yes</th>
<th>Minimal Change Needed</th>
<th>Changes Needed</th>
<th>Major Barrier</th>
</tr>
</thead>
</table>

Actions Required to Become Fully Ready / Comments:

---

4. **Does the proposed program have a champion?**

Identified Champion

<table>
<thead>
<tr>
<th>Yes</th>
<th>Minimal Change Needed</th>
<th>Changes Needed</th>
<th>Major Barrier</th>
</tr>
</thead>
</table>

Name:_________________________ Role:__________________

Decision Makers Interest

<table>
<thead>
<tr>
<th>Yes</th>
<th>Minimal Change Needed</th>
<th>Changes Needed</th>
<th>Major Barrier</th>
</tr>
</thead>
</table>

Name:_________________________ Role:__________________

Support for Initiative

<table>
<thead>
<tr>
<th>Yes</th>
<th>Minimal Change Needed</th>
<th>Changes Needed</th>
<th>Major Barrier</th>
</tr>
</thead>
</table>

Actions Required to Become Fully Ready / Comments:

---
5. Do stakeholders support the program?

Stakeholder program perceptions

Stakeholder program education

Name: ____________________ Role: __________

Name: ____________________ Role: __________

Actions Required to Become Fully Ready/Comments:

6. Who has authority over the proposed program?

Program Authority

Name: ____________________ Role: __________

Name: ____________________ Role: __________

Actions Required to Become Fully Read / Comments:

7. What does the SWOT analysis reveal about organizational successes and potential barriers?

Internal Factors (skill sets, strengths, weaknesses)

External Factors (opportunities, challenges)

Actions Required to Become Fully Ready / Comments:
# Organizational Readiness Assessment Summary

*Use this template if an Executive Summary of the Readiness Assessment is desired.*

<table>
<thead>
<tr>
<th>Date:</th>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of Desired Initiative:</td>
<td></td>
</tr>
</tbody>
</table>

**RATE READINESS FACTORS** Record all of your answers from the organizational readiness assessment in the appropriate boxes below.

<table>
<thead>
<tr>
<th>Not Ready</th>
<th>Substantial Barrier</th>
<th>Significant Changes Needed</th>
<th>Minimal Changes Needed</th>
<th>Full Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Barrier</td>
<td>Substantial Barrier</td>
<td>Significant Changes Needed</td>
<td>Minimal Changes Needed</td>
<td>Full Support</td>
</tr>
<tr>
<td>Alignment with Organizational Vision / Mission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alignment with Strategic Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alignment with Organizational Values /Culture</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource Availability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified Champion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision Makers Interest</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for Initiative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stakeholder program perceptions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stakeholder program education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Authority</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Factors (skill sets, strengths, weaknesses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Factors (opportunities, challenges)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Overall Rating</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**List of Actions Required to Become Fully Ready:**

**Recommendation:**

- Move Forward Now
- Make Necessary Changes
- Reassess in __ months
- Not appropriate
Needs Assessment Worksheet

Define the Purpose

1. What is the purpose and scope of your needs assessment?

Data Collection

2. What data are you going to collect?

3. What tools will you use to gather the data?
**GAP Analysis**

4. What is the current state of your organization? (i.e. healthcare services your organization currently provides, how those services are delivered, number and type of providers, available local resources). What are the unmet community and market needs?

<table>
<thead>
<tr>
<th>Current State of Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

5. What is the desired state of your organization? (i.e. supplemental services, delivery capability, providers and other support that is needed). What community needs can telemedicine support?

<table>
<thead>
<tr>
<th>Desired State of Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
6. What is the gap between your current state and your desired state? Are there new or extended health care services that must be provided in order to reach the desired state?

7. How can telemedicine be used to help reach the desired state?

Potential Barriers

8. Are there any potential barriers to implementing a telemedicine program? (i.e. financing, training, lack of technical support)
9. Based on these barriers, what revisions will you need to make to your desired state to allow for any barriers that are perceived unavoidable?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Service Priorities

10. Now that you have identified the desired state and the services that can be enhanced using telehealth, rank your service needs by priority.

1.

2.

3.

4.

5.
Step Two
Define & Specify Program Model

Questions to Answer

- What services have you decided to provide?
- How will the services be provided?
- What is the proposed scope and implementation strategy?
- What technology model will you use?
- Do you have authority, support & resources to move forward?

Products and Activities

- Develop program goals and objectives
- Develop preliminary service description
- Develop preliminary telehealth delivery model
- Identify implementation approach
- Create program charter

Everyone loves Step Two! Step Two identifies the specific clinical services your telemedicine program will target and the telemedicine program model that will be used to deliver those services. You will identify the services you want to target, any geographical boundaries, what form of telemedicine you will implement and the most appropriate program model for your particular organization. During Step Two you gather information and consider what the program would look like and how it can be structured as an integral and valued strategic organizational element. You will also consider your implementation approach – pilot, one service only, limited sites, etc.

In this step you will review your prioritized list from the needs assessment, and then research the types of telemedicine that might address these needs. You will then collect some very preliminary application cost data for various telehealth models to explore which might work for you. This step blends into Step Three where the information from Step Two will be expanded to create a business model, business case and more detailed cost estimates.

At the completion of this Step, you will have a high-level understanding of what is needed clinically, technologically, and organizationally in order to deliver the targeted telemedicine services in the proposed way.

In a nutshell: During Step Two you will:
- Decide on the type of services to be provided – prepare a preliminary program description
• Decide on the type of telehealth program that best works for your application and prepare a preliminary program model description
• Consider assumptions, constraints, opportunities
• Create high level cost estimates
• Create a written proposal or Program Charter

Some organizations bring together a small group to define the program and technology model while others may be ready to bring a larger team together at this point in the development.

As you continue to develop and define the specifics of the program during subsequent steps, the preliminary decisions may need to be revisited and revised.

**Activities**

1. **Develop program goals and objectives**

   Measurable goals based on your decisions about service needs will assist you in identifying the scale of the program, equipment needs, estimating workload associated with the new program, and creating a basis for program evaluation.

2. **Develop a preliminary service and program description**

   The program proposal describes the type of service that will be provided:
   • Proposed telehealth services;
   • Alternatives considered and reasons for proposed solution;
   • High-level description of the program model to be adopted, the rationale, and how it would be incorporated into existing service delivery;
   • High-level description of what is required in order to support the identified program model. This description will include general technology requirements (e.g., live interactive, store and forward); specific types of health care providers; specific sources of services (e.g., city hospital); and
   • Preliminary costs associated with supporting the programs high-level requirements (e.g., space, staff).

   The service and program description documents your research and recommended decisions. It can be a standalone report, can be incorporated into the preliminary telemedicine delivery model or may be part of a Program Charter.

**Tools for this Activity:**
• Simple Charter
• Charter Template
• Kick Off Meeting Template
3. **Develop a preliminary telehealth delivery model**

A Telemedicine Program Model defines the choice of telehealth, selecting the most appropriate model for your situation and service selection. The preliminary telemedicine program model includes:

- The telemedicine delivery method proposed for providing the service; (e.g. live interactive with a telemedicine system on a clinician’s desktop);
- High-level requirements of the telemedicine system and equipment including requirements for interoperability, network and storage capability and available support for IT; and
- Preliminary cost estimates for technology components of the proposed program.

The telehealth delivery model documents your research and recommended decisions.

It can be a standalone report, can be incorporated into the preliminary service and program description or may be part of a Program Charter.

**Tools for this Activity:**
- Step Two Program Model Checklist
- Program Charter Template

4. **Develop implementation approach**

Consider the best approach for implementation – a small pilot with limited service provision followed by expansion, a limited number of sites initially, one type of telehealth (e.g. live interactive) followed by another application (e.g. provider education). Many programs find small steps useful others find larger implementations successful. Decisions are often based on available resources, risk tolerance of the organization, time available, and the opinions of champions and decision-makers.

5. **Create a Charter or other written report**

Many find it very helpful to develop a Charter to document the information that has been gathered to date. Charters contain background on the reason telehealth is being considered, information on the problem, desired solutions, assumptions, constraints, desired timeframes, approvals and other critical information. A Charter assures that important initial decisions are well documented prior to moving on to the detailed planning for the program.

**Tools for this Activity:**
- Program Charter – Template
- Program Charter - Sample
Have you covered everything?

Take a look at the Step Two Checklist. You may see some things to consider before you move on.

**Define & Specify Program Model Checklist**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You know which services will be offered to meet the identified patient needs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. You have identified the mode of service delivery.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. You have determined who will provide the service and where will they are located.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. You have identified the organizational model that will best suit your patient needs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. You have identified any constraints based on your organization, for example federally qualified health center rules.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. You know the general technological features &amp; functions that are needed to deliver the target services in the proposed way.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Of the choices of technology, you have selected the one most appropriate for your program.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. You have identified any additional human resources needed and where they will be located.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. You have identified any additional facility-related resources needed and where they will be located.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. You have identified any legal, legislative or regulatory constraints that your organization would need to consider when developing your telehealth program.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. You have determined your program’s implementation approach (i.e., phased, pilot project, demonstration project)?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I. Background and Problem Statement

Give any background information that will help explain how the project came to be.

Describe the reasons for initiating the project, specifically stating the clinical and/or business problem. Explain why the project is needed. If applicable, include details of why existing services are inadequate. The subsequent needs analysis (if not already performed) would provide more information. This is what appears to be driving the project.

II. Project Description and Scope

Provide a description of the project, defining the project scope, being careful to note boundaries and limitations. The project scope should be clearly detailed so that all parties involved are very aware of exactly what the project includes as well as what it doesn’t. As more detail about the project is developed, the scope may need revision. The Charter would also be revised.

Clearly state all goals and quantitative objectives for the project.
**Project Scope**

Provide a description of the project scope, being careful to identify boundaries and limitations. The project scope should be clearly detailed so that all parties involved are very aware of exactly what the project includes as well as what it doesn’t. As more detail about the project is developed, the scope may need revision. The Charter would also be revised.

<table>
<thead>
<tr>
<th>Project Includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Excludes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Assumptions**

Describe any project assumptions related to need, clinical services, business, technology, resources, scope, expectations, or schedules.

**Constraints**

Describe any project constraints being imposed in areas such as schedule, budget, resources, and technology to be employed.
Major Projects and Milestones

List the project’s preliminary major milestones and deliverables with the planned completion dates for delivery. This list will be expanded and revised during Phase II – Program Development.

<table>
<thead>
<tr>
<th>Milestone/Deliverable</th>
<th>Planned Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

III. Governance and Oversight

Provide a list of names identifying the major parties involved in the project, such as project sponsors, stakeholders, and eventual project owners. In addition, be sure to identify the role of each individual listed so that there is no confusion concerning responsibilities later down the line.

Identify team members and Summarize roles and responsibilities for this project.

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Development Team

Telehealth Program Developer
Sponsorship and Ownership

Identify who has authority for the project including any external oversight bodies and organizational policies.

IV. Reference Materials

List any related documents or other resources that could be helpful in understanding various aspects of the project, such as the scope and need.

Terminology

Use this section to identify any special terms related to the project that will need to be known to anyone related to the project.

Approvals

Approval of the Project Charter indicates an understanding of the purpose and content described in this deliverable. By signing this deliverable, each individual agrees with the direction and outlined details of the project and agrees to move forward with the project.

<table>
<thead>
<tr>
<th>Approver Name</th>
<th>Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
V. Approvals and Revision History

Keep track of changes to the Charter

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I. Background and Problem Statement

Hospital In The Woods will be receiving telemedicine equipment for use in their facility through grants awarded by the State Rural Health Office and a private foundation. The grant also provides funding for a part time telemedicine coordinator. Hospital In The Woods formed a telemedicine committee to look at how telemedicine might benefit their organization. The committee is meeting on a monthly basis.

Hospital In The Woods is a small Joint Commission accredited 25-bed critical access not-for-profit hospital located in Anywhere, CA. The rural location of Anywhere is a serious barrier to receiving specialty care especially during winter months when travel is severely restricted due to snow levels. Anywhere is designated as a rural HPSA area for Medicare.

NIH sees a potential need for oncology, rheumatology, cardiology, dermatology and possibly psychiatry services. Over 150 specialty referrals are made monthly.

Payer mix Medicaid 35%, Medicare 25%, Uninsured 18%, Commercial 22%. There are concerns that Medicaid and Medicare payer mix may limit reimbursement.

II. Project Description and Scope

Implement outpatient oncology services at the Hospital In The Woods Rural Health Clinic. Initial implementation will be providing Oncology services to patients at this facility.

This project will undertake the activities and tasks required to implement services, including equipment procurement, development of work flows, clinical and operational policies and procedures, business model development, clinical service provision, billing and scheduling, staffing, service coordination and performance monitoring.

Hospital In The Woods is working with the CTRC to coordinate necessary work, create a business model and a training manual for telemedicine billing.
Improve Access to Clinical Service
Provide 10 telemedicine oncology consults per month. Reduce travel for patients and wait times for visits.

Maximize Administrative Efficiency and Revenue
Reduce facility revenue lost when patients are required to obtain services outside the hospital/clinic. Optimize reimbursement with availability of current reimbursement schedules.

Build A Program Foundation That Will Allow for Expansion and Sustainability
Assess the impact of telehealth at 3 months, 6 months and one year. Prepare business model for expanded services. Identify grant opportunities for further funding of Telehealth.

Project Scope
Project Includes:
- Development of Oncology outpatient services provided from the Rural Health Clinic
- Development of program operations including policies procedures and clinical coordination
- One patient site
- Identifying Oncology provider for telehealth service delivery
- Working with local clinicians to engage them in Telehealth

Project Does Not Include:
- Implementation of other clinical specialties until oncology is operational
- Wireless applications
- Any additional patient sites

Assumptions
- Begin providing services in MM/YYYY
- Equipment and peripherals to be procured in a timeframe that supports service startup
- Adequate broadband is available for live interactive telehealth
- Remote oncology service provider is interested in telemedicine
- All grant funds are approved and received as expected
- Current staffing will support development efforts and activities

Constraints
- Two grants are only source of funding
- Current staff will be required to perform implementation tasks in addition to current workload
### Major Milestones

<table>
<thead>
<tr>
<th>Milestone/Deliverable</th>
<th>Planned Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### III. Governance and Oversight

### IV. Reference Materials

- Project Scope of Work
- CTRC Organizational Readiness Assessment Template
- CTRC Reimbursement Guide
V. Approvals and Revision History

Approval of the Project Charter indicates an understanding of the purpose and content described in this deliverable. By signing this deliverable, each individual agrees with the direction and outlined details of the project and agrees to move forward with the project.

<table>
<thead>
<tr>
<th>Approver Name</th>
<th>Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Document changes to the Charter and subsequent revision approvals.

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Telehealth Kickoff and Planning Meeting Template

2 - 4 hours is usually a sufficient time for a kick off meeting

*Purpose: To begin development of a plan to implement appropriate telehealth technology*

*Attendee List:*

<table>
<thead>
<tr>
<th>Project Sponsor</th>
<th>Director of Information Technology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive Officer</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>Chief Medical Director</td>
<td>Clinic Manager</td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td>Telemedicine Coordinator</td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>Medical Director</td>
</tr>
</tbody>
</table>

- Bring Team Together
  - Welcome and Introductions
  - Objectives of Meeting
- Overview of Telehealth
- Applying A Development Process
- Predictors of Success
- Consider Organizational Readiness
  - Assessments
- Development of a Charter
- Create a Development Plan
  - Review Needs and Possible Opportunities
  - Identify Implementation Team
  - Identify Information Needed
- Identify Next Steps
Step Three

Develop Business Case

<table>
<thead>
<tr>
<th>Questions to Answer</th>
<th>Products and Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What is the proposed scope of the program?</td>
<td>• Market Analysis</td>
</tr>
<tr>
<td>• What is the estimated demand for the service?</td>
<td>• Business Case Report</td>
</tr>
<tr>
<td>• What service and technology estimates are being used for the cost projections?</td>
<td></td>
</tr>
<tr>
<td>• What is the financial model associated with the proposed program?</td>
<td></td>
</tr>
<tr>
<td>• How will the program impact the organizations financial position?</td>
<td></td>
</tr>
<tr>
<td>• Is the program sustainable? What is the sustainability model?</td>
<td></td>
</tr>
<tr>
<td>• Will the program create revenue in another area of the organization?</td>
<td></td>
</tr>
<tr>
<td>• Will the program require subsidy from the organization?</td>
<td></td>
</tr>
<tr>
<td>• Is there a demonstrated Return on Investment?</td>
<td></td>
</tr>
<tr>
<td>• Is the organization willing to implement if there is not a revenue positive or neutral program design?</td>
<td></td>
</tr>
<tr>
<td>• Will grants be required for program initiation and/or sustainability?</td>
<td></td>
</tr>
</tbody>
</table>

Step Three assists with evaluating the service demand, cost, benefits, risks and other elements of the proposed telemedicine program and assists with consolidating the outcomes into a business case report. This step brings together the information and analysis done during the needs assessment and the preliminary program development, and adds a financial and market analysis to determine the business model for the program and how the proposed telehealth program would financially impact the organization.

A clear understanding of the proposed program’s financial impact is necessary along with consideration of the risks associated with the implementation and decisions on the business model. Developing a business model that supports program sustainability has been a challenge for many telemedicine programs. In many cases, the program may provide beneficial access to care without supporting the organization’s bottom line. This may be perfectly acceptable given an organization’s mission and other sources of revenue. However, it is preferable to know the financial impact before proceeding.

The business case development looks at the estimates for service delivery, the costs to develop and operate the program and any sources of revenue or fiscal impact, positive or negative to describe the overall impact of the program on the program’s financial picture. A market analysis during this step of the development will determine if there is an effective demand or market for the proposed service.
Sometimes it is assumed that since there is a need for the service that there is automatically a demand for the service. It is important to determine what purchasing power is available to obtain or pay for the fulfillment of the identified need with telehealth. If purchasing power or revenue to support the program cannot be identified, there may not be a good business case for the program. A market analysis explores whether there is a desire, willingness and the means to obtain or pay for the service.

The formality and level of detail presented in the Business Case Report depends primarily on:

- The scope of the proposed telemedicine program. Is this an extension to an existing telemedicine program or is it the first implementation of a telemedicine program? Large programs and first time implementations benefit from a formal and detailed business model and business case report.
- The audience for the Business Case Report (i.e., a Board of Directors, a granting agency, a bank, a venture capitalist) and the information they require.

**Activities**

1. **Business Case Report (sometimes called a business plan):**

   A Business Case Report correlates with elements of a market analysis, a strategic plan, an operational/management plan, a financial plan, an environmental scan and information from the needs analysis and preliminary program proposal.

   The Business Case Report generally contains:
   - Description of the need for the telemedicine program (using the work products created during Step One, Determine Needs);
   - Description of how the proposed program aligns with the organization's existing mission, lines of business, and/or strategic plans;
   - Description of the market and demand for the service;
   - Cost estimates;
   - A fiscal analysis and Return on Investment (ROI) calculated for the telemedicine program;
   - Description of how program development and implementation will be structured and managed;
   - Description of how the program will be promoted;
   - Description of how the ongoing operations will be managed and what resources are needed (including financial);
   - Projected fiscal impact of the program on the organization’s; and
   - Evaluation of risks and constraints.

**Tools**

- Needs Assessment
- Market Analysis Guide
- Market Analysis Template
Have you covered everything?

Take a look at the Business Case Checklist. You may see some things to consider before you move on.

### Business Case Checklist

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>You have determined the approximate start up and operating costs for your telehealth program.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>You have determined how the benefits of telehealth relate to the mission of your organization and the needs of the community.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>You have identified the payer mix.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>You have obtained financial commitment to implement and sustain your telehealth services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>You know the approximate expected cost reductions (e.g., providers who no longer travel to remote clinics).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**End With A Review!**

Include a critical review at the end of each program development step so stakeholders and decision makers can evaluate results obtained thus far and make informed decisions about continuing to invest time and resources to further develop the telemedicine program as currently envisioned. Whether a decision about moving forward requires the formal approval of a board or the informal consensus of your program development team, including a critical review at the end of each step better ensures the organization will make a conscious decision about further program development. Of equal importance, these reviews and decision-points also provide opportunities to secure organizational engagement and buy-in for the emerging telemedicine program.
Step Four
Plan Program and Technology

<table>
<thead>
<tr>
<th>Questions to Answer</th>
<th>Products and Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What are the clinical program requirements?</td>
<td>• Detailed Program Implementation Plan</td>
</tr>
<tr>
<td>• What are the operational program requirements?</td>
<td>• Detailed Technology Implementation Plan</td>
</tr>
<tr>
<td>• What are the technology requirements?</td>
<td></td>
</tr>
<tr>
<td>• How will these requirements be met?</td>
<td></td>
</tr>
<tr>
<td>• What tasks will be required to create and implement all clinical, operational and technical functions?</td>
<td></td>
</tr>
</tbody>
</table>

Step Four creates two major products. Step Four identifies the detailed programmatic and technical requirements necessary for delivery of the targeted services and creates a comprehensive project plan. This information will be used to procure services and equipment and to staff the program.

Step Four adds more detail to the information collected in Step Two. In this step, all the information about the clinical program and requirements, the technical requirements, and operational models are defined in greater detail.

In a Nutshell: Step Four creates the detailed task lists that will be used during your program’s implementation (Step Six). At the end of Step Four you should have:

- A complete description of equipment specifications, clinical requirements, operational and staffing requirements
- A complete task list for implementing each of the areas.
- An Implementation Plan that includes assigned tasks, assigned resources, preliminary timelines, and schedules.
- Definition of the approach that will be used in implementing the program
**Activities**

1. **Detailed Program Implementation Plan**

A detailed program implementation plan should be developed for the clinical services, operational, and administrative portions of the telehealth program. The detailed Program Implementation Plan will include:

- a detailed description of the clinical services, operational requirements, estimated volumes and other requirements.
- a complete listing of the tasks required to achieve implementation of the program including staffing, clinical services, site coordination, operations, room preparation, training, and marketing and communication.
- preliminary timelines, schedules and estimates of required effort and resources.

2. **Detailed Technology Plan**

The Technology Plan will include:

- Detailed technical requirements and specifications for all technology components, defined requirements for service level agreements, list of targeted products, services, and vendors (including projected one-time and continuing costs).
- A complete listing of tasks necessary to implement and operate all technology components of the telemedicine program.

If, in completing Step Four, you find that the information is substantially different than the originally projected approach, the Business Case developed in Step Three may need to be revisited and revised.
Have you covered everything?

Take a look at the Step Four Checklist. You may see some things to consider before you move on.

### Plan Program and Technology Checklist

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You have identified the activities or steps that you will undertake to achieve your telehealth objectives</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. You have developed a plan that you will need for managing the work involved in establishing a telehealth program.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. You have identified who in a leadership position in the organization will be involved in your program and what their role will be.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. You have identified members of your telehealth team and their roles and responsibilities.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. You have developed a communication strategy to promote your telehealth services.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. You have developed policies and procedures for operation of the program.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. You have a suitable space for telehealth.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. You have determined how appointments will be scheduled.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. You have determined how referrals will be made.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10. You have identified the type of training needed and who needs to be trained.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11. You have developed clinical referral guidelines.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>12. You have determined how telehealth will be integrated into clinic operations.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>13. You have identified the detailed attributes of hardware, software, and telehealth (i.e., bandwidth, product standards, and product features).</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>14. You have defined the necessary service level and support agreements.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15. You have identified the interoperability and scalability requirements.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>16. You have identified the existing organizational resources that can be used to meet specified requirements (e.g., existing network, hardware, equipment).</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>17. You have identified the types of approvals or authorizations required to assign existing resources to the telehealth services.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>18. You know the organization’s procurement policies and procedures.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Step Five

Develop Performance Monitoring Plan

Questions to Answer

- How will regular program performance be monitored and assessed? What data elements are required? How will they be collected? What management reports will be produced?
- How will the program be evaluated? On what criteria? Using what methodology?
- How will program modifications and improvements be identified and implemented?

Products and Activities

- Performance Monitoring Plan
- Evaluation Plan
- Quality Improvement Process

Step Five identifies how the telemedicine program will be monitored and evaluated to determine if it is successfully meeting program objectives.

During Step Five you will decide what data you need to collect in order to assess progress and achievement of objectives, determine how you will collect the necessary data, develop report formats, and develop a schedule for monitoring and reporting program performance. The information gathered about the program will be used to identify and implement program improvements throughout the life of the program (see Step Seven).

Don’t Overlook This Plan

While the Performance Monitoring Plan could be considered as part of Step Four, it is often overlooked until the program is operating and the data necessary for an adequate evaluation is not being collected. Because of the importance of evaluation and monitoring, it has been separated into a distinct step.

During Step Five, the process for reviewing performance, identifying improvements, and implementing changes should be identified and documented. As with any program, modifications and enhancements are necessary for optimal performance. Many organizations have formal quality improvement processes that are used to identify and implement improvements. If one is not available, a quality improvement process should be identified and documented during Step Five.
In a nutshell: During Step Five, program evaluation will be addressed. In addition to making decisions on formal evaluation efforts, routine program performance monitoring will be considered. At the end of Step Five you should have:

- Selected performance indicators, corresponding data elements, data collection mechanisms, and a plan for developing and implementing the performance monitoring process.
- Determine what type of program evaluation may be desired or required, and developed implementation plans for the evaluation activities.
- Developed process for reviewing performance monitoring data and evaluating and implementing improvements in the program.

**Activities**

1. **Performance Monitoring Plan**

A detailed program implementation plan should be developed for the clinical services, operational, and administrative portions of the telehealth program. The detailed Program Implementation Plan will include:

**Tools:**

Performance Monitoring Indicators Matrix

2. **Quality Improvement Process**

The Quality Improvement Process should provide written documentation on the manner in which the program will implement quality improvement. It should document the improvement structure, reviewing performance, submitting improvement suggestions, and monitoring implementation of improvements.

**Data Collection Should Start Immediately**

Data collection does not have to be difficult especially when it is designed into work flows and operational processes. It can, however, become very daunting and time consuming when the data has to be retrieved after the program has begun. Gathering data and reporting on performance will assist your program in obtaining organizational support, funding, and further expansion of services. Remember to match your data design with the baseline data collected during the needs assessment.
Revised to include data elements or aggregated data elements. Also includes column to consider core, desirable or remove. Decisions would be impacted by the aggregated data element matrix.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Elements/Aggregated Data Elements</th>
<th>Purpose / Value</th>
<th>Outpatient Services</th>
<th>Chronic Disease Home Monitoring</th>
<th>eICU</th>
<th>ED Services</th>
<th>Admin</th>
<th>Educational Services</th>
<th>Selected Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Performance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Percent of all health services / encounters performed using telehealth: total and by specific service type.</td>
<td>• <strong>Non telehealth services/ encounters</strong> total number total by service type • <strong>Services provided / obtained through telehealth:</strong> total number total by service type</td>
<td>Indicates overall use of telehealth in the facility – total and by specific service types.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Telehealth services provided: total and by type</td>
<td>• <strong>Completed telehealth encounters:</strong> total number total by service type</td>
<td>General overview of telehealth use</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. Clinical services provided: total and by type</td>
<td>• <strong>Clinical service encounters:</strong> total number total services by type</td>
<td>General overview of clinical services.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. Administrative services provided: total and by type</td>
<td>• <strong>Administrative service usage:</strong> total number total services by type total participants total hours</td>
<td>General overview of administrative services. Types could include: • Administrative meetings • Community / business non-health meetings • Commercial conferencing services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Educational services provided: total and by type</td>
<td>• <strong>Educational services provided:</strong> total number total number by type total attendees total hours</td>
<td>General overview of educational services. Types could include: • Education for health professionals</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Data Elements/Aggregated Data Elements</td>
<td>Purpose / Value</td>
<td>Outpatient Services</td>
<td>Chronic Disease Home Monitoring</td>
<td>eICU</td>
<td>ED Services</td>
<td>Admin</td>
<td>Educational Services</td>
<td>Selected Indicators</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------------</td>
<td>----------------</td>
<td>---------------------</td>
<td>-------------------------------</td>
<td>------</td>
<td>-------------</td>
<td>-------</td>
<td>----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>6. Clinical versus non-clinical uses, in percent.</td>
<td>• Clinical encounters: Total • Non-clinical encounters: Total</td>
<td>General indicator of service use</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>7. Percent of requested telehealth services / encounters that were successfully scheduled.</td>
<td>• Telehealth encounters requested: total number of requests total number by type • Telehealth encounters scheduled: total number scheduled total number scheduled by type</td>
<td>• May identify telehealth provider shortages or long wait times. • May identify scheduling operations problems.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>8. Percent of scheduled telehealth encounters completed.</td>
<td>• Telehealth encounters scheduled: total number scheduled total number completed total number completed by type</td>
<td>Alerts to low completion rates. May be affected by (partial list): provider availability, technical problems, patient site staffing, patient no show</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>9. Percent of scheduled telehealth encounters not completed: total, by type, and by specific reason.</td>
<td>• Telehealth encounters scheduled: total number scheduled total number by type • Telehealth encounters not completed: total number completed total number by type Not completed by specific reason</td>
<td>Alerts to low completion rates. Reason codes could include: • Provider not available • Patient failed to appear • Patient presenter unavailable • Participants not available • Patient refused service • Required workup/ tests results or other clinical data not available</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Data Elements/Aggregated Data Elements</td>
<td>Purpose / Value</td>
<td>Outpatient Services</td>
<td>Chronic Disease Home Monitoring</td>
<td>eICU</td>
<td>ED Services</td>
<td>Admin</td>
<td>Educational Services</td>
<td>Selected Indicators</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------</td>
<td>----------------</td>
<td>---------------------</td>
<td>---------------------------------</td>
<td>------</td>
<td>-------------</td>
<td>-------</td>
<td>----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>10. Percent of encounters that are started but cannot be completed: total and by reason.</td>
<td>• Telehealth encounters started Total Total by type • Telehealth encounters started but not completed Total Total by type Total by reason</td>
<td>Alert to low completion rates. Reasons could include: • Patient refused after visit began • Presenter of provider call away during visit • Required work/up test results not available • Technical/Equipment problem</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>11. Percent of patient refusals: total and by reason.</td>
<td>• Scheduled telehealth encounters: Total scheduled Total by type • Patient refusals: Total refusals Total by type Total by reason</td>
<td>Monitors refusal rates and reasons for refusal. Reasons could include: • Uncomfortable with technology • Unsure that technology is effective • Want to see doctor in person</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>12. Completed encounters impacted by a technical issue: percent of total completed encounters and percent by reason.</td>
<td>• Encounters completed: Total completed Total by type • Encounters with technical issue reported Total Total by specific reason</td>
<td>Monitors types of technical situations that are impacting operations. By capturing the reasons, performance improvement measures can be implemented. Reasons could include: • Dropped calls • Poor video quality • Poor audio quality • Diagnostics not working</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>13. Scheduled encounters cancelled or not completed due to technical issues: percent of total scheduled encounters and percent by</td>
<td>• Scheduled telehealth encounters: Total scheduled Total scheduled by type</td>
<td>Monitors types of technical situations that are causing service cancellations. Reasons could include:</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Data Elements/Aggregated Data Elements</td>
<td>Purpose / Value</td>
<td>Outpatient Services</td>
<td>Chronic Disease Home Monitoring</td>
<td>eICU</td>
<td>ED Services</td>
<td>Admin</td>
<td>Educational Services</td>
<td>Selected Indicators</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------------</td>
<td>----------------</td>
<td>---------------------</td>
<td>--------------------------------</td>
<td>------</td>
<td>-------------</td>
<td>-------</td>
<td>----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>reason (13, 14).</td>
<td>• Scheduled telehealth encounters cancelled or not completed due to technical issues: Total Total by reason</td>
<td>• No network connection • Dropped calls • Poor video quality • Poor audio quality • Diagnostics not working</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Most frequent times for Telehealth services delivery.</td>
<td>• Encounter start time</td>
<td>This has value for “on demand” telehealth services to identify staffing patterns.</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Average time from Telehealth service request to Telehealth encounter scheduled – non high risk.</td>
<td>• Encounter request date • Encounter scheduled date</td>
<td>Provides information on scheduling system performance and provider availability.</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Average time from service request to the on demand provider to start of the encounter – high risk.</td>
<td>• Time encounter requested • Time encounter scheduled</td>
<td>Provides information on scheduling system performance and provider availability.</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Average time from identification of need for a Telehealth encounter until S&amp;F package sent.</td>
<td>• Date and time of patient image capture • Date and time of Store and Forward Package Transmission</td>
<td>Store and forward service type specific. This detects patient site performance issues.</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Average time from S&amp;F package sent to assessment/results returned.</td>
<td>• Date and time of Store and Forward package transmission All services By service type • Date and time of provider response</td>
<td>Store and forward service type specific. This detects remote provider site performance issues.</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Average time per telehealth encounter (including prep and charting): all services and by specific service type.</td>
<td>• Start time of encounter • End time of encounter • Specific service type</td>
<td>Provides information on total encounter time at either patient or provider side. Useful for scheduling.</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x x</td>
<td></td>
</tr>
<tr>
<td>20. Average number of video minutes per encounter: total and by</td>
<td>• Start time of live video • End time of live video</td>
<td>Provides information on time required for different</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x x</td>
<td>x</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Elements/Aggregated Data Elements</th>
<th>Purpose / Value</th>
<th>Outpatient Services</th>
<th>Chronic Disease Home Monitoring</th>
<th>eICU</th>
<th>ED Services</th>
<th>Admin</th>
<th>Educational Services</th>
<th>Selected Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>specific service.</td>
<td>• Service type</td>
<td>specialties / services (without pre and post provider activity. Useful for scheduling, service negotiations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 21. Time required to obtain service telemedicine versus non-telemedicine: total and by specific service. | • Estimated time to in person service delivery  
  Specific Type  
  Service method  
  Date of service telehealth request  
  Date of service telehealth encounter | Indicates relative availability of telemedicine services; ability to impact service scheduling | x | x | x | x | x | x |
| 22. Percent of allocated telehealth appointment time used. | • Time allocated to Telehealth appointments  
  Allocated time used for appointments | Measures use of available resources and available resources unused. | x |                 |   |             | x | x |                     |
| 23. Result of telehealth encounter by reason. | • Total encounters  
  Encounter result by reason | Reasons may include:  
  • Corroborated initial diagnosis/treatment plan  
  • Resulted in definitive diagnosis/treatment plan  
  • Confirmed need for face to face visit with remote provider  
  • Confirmed need for urgent/emergent transport  
  • Avoided need for face to face visit with remote provider  
  • Avoided need for urgent/emergent transport  
  • No change in diagnosis or treatment plan  
  • Changed diagnosis or treatment plan | x | x | x | x | x | x |
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Elements/Aggregated Data Elements</th>
<th>Purpose / Value</th>
<th>Selected Indicators</th>
</tr>
</thead>
</table>
| 24. Telehealth services by delivery method.                              | • Telehealth encounters completed  
• Total number by delivery method                                                                                   | Provides distribution by delivery method. Methods could include:  
• Live interactive  
• Store and Forward  
• Hybrid  
• Telemetry                                                                                                         | ED Services         |
| 25. Percent of patient encounters no subsequent in-person required.       | • Total number of telehealth encounters  
• Total number of telehealth encounters with no subsequent in-person required | Provides information on how often telehealth visits replaced an office visit?                                                                                                                                     | Admin               |
| 26. Primary diagnosis by service type                                     | • Service type  
• CPT codes for primary diagnosis  
• CPT codes for secondary diagnosis                                                                                           |                                                                                                                            |                     |
| Home/Chronic Disease monitoring                                           |                                                                                                                                                      |                                                                                                                            |                     |
| 27. Improved quality of life scores Aggregate change in quality of life rating; percent improved percent no change percent decreased. | • Quality of Life scores                                                                                                                              | Provides improvement in Quality of Life rates through telehealth use. Balances under patient measures provider.                                                                                           |                     |
| 28. Physiologic measurements collected by type compared to number indicated in care plan. | • Number physiologic measures scheduled for collection  
• Number physiologic measures collected                                                                                           | Non adherence to care plan by type: human and technology.                                                                                                                                     |                     |
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Elements/Aggregated Data Elements</th>
<th>Purpose / Value</th>
<th>Outpatient Services</th>
<th>Chronic Disease Home Monitoring</th>
<th>eICU</th>
<th>ED Services</th>
<th>Admin</th>
<th>Educational Services</th>
<th>Selected Indicators</th>
</tr>
</thead>
</table>
| 29. Percent change in admission and readmission rates. | - Average readmission rate before Telehealth  
- Average readmission rate after Telehealth | Provides change in inpatient admissions resulting from telehealth use. | x | | | | | | |
| 30. Percent change in visits to Primary Care Provider | - Average PCP visit rate before Telehealth  
- Average PCP visit rate after Telehealth | Provides reduction in PCP visits resulting from telehealth use. | | | | | | x | |
| 31. Average number of in-home care nurse encounters per episode of care for home monitoring telehealth programs. | - Number of in-home nurse encounters  
- Number of episodes of care | Provides overall utilization on nursing services | | | | | | x | |
| 32. Nurse contacts per episode of care due to out of range reading NEW | - Nurse contacts for out of range readings  
- Number of episodes of care | Provides information on out of range readings per episode of care | | | | | | x | |
| 33. Average time between in-home nurse interventions compared to non telehealth | - Number of home clinical visits  
- For telehealth enrollees  
- For non telehealth enrollees  
- Number of days between visits  
- For telehealth enrollees  
- For non telehealth enrollees | Allows tracking of the length of stable periods | | | | | | x | |
| 34. Unplanned telehealth encounters by episode of care | - Number of unplanned telehealth encounters  
- Number of episodes of care | | | | | | | x | |
| 35. Average number of nurse encounters per unit of time (hour, shift). | - Number of nurse encounters  
- Unit of time | Provides productivity information | | | | | | x | |
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Elements/Aggregated Data Elements</th>
<th>Purpose / Value</th>
<th>Outpatient Services</th>
<th>Chronic Disease Home Monitoring</th>
<th>eICU</th>
<th>ED Services</th>
<th>Admin</th>
<th>Educational Services</th>
<th>Selected Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>eICU</td>
<td></td>
<td>Provides reduction in mortality rate through telehealth use. Requires historical data collection and comparison. A common indicator for effectiveness and cost avoidance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 36. Percent change in mortality rate.          | • Average mortality rate before Telehealth  
• Average mortality rate after Telehealth  
• Average ICU length of stay before Telehealth                                                                                                                        |                                                                                                                                                                                                              |                     |                                 |      |             |       |                      |                   |
| 37. Percent change in ICU length of stay.      | Telehealth  
• Average ICU length of stay after Telehealth                                                                                                                  | Provides reduction in ICU length of stay that in eICU programs use. Required historical data for comparison.                                                                                                      |                     |                                 | X    |             |       |                      |                   |
| 38. Percent change in complications.           | • Average complication rate before Telehealth  
• Average complication rate after Telehealth                                                                                                                                | Provides reduction in complications in eICU programs. Requires historical data collection and comparison. Provides reduction in overall length of stay in eICU programs. Requires historical data for comparison. |                     |                                 |      |             |       |                      |                   |
| 38. Percent change in complications.           | • Average length of stay before Telehealth                                                                                                                                         |                                                                                                                                                                                                              |                     |                                 |      |             |       |                      |                   |
| Emergency Department                           |                                                                                                                                                                                                                                       | Provides a measure of telehealth impact on delivery of TPA in appropriate cases. Requires historical data comparison.                                                                                              |                     |                                 |      |             |       |                      |                   |
| 40. Percent of appropriate TPA Percent reduction in overall length of stay. delivery in allowable timeframe. | • Number of patients presenting with stroke symptoms that are eligible for TPA.  
• Number of patients TPA was administered within the allowable timeframe.                                                                                                    | Provides a measure of telehealth impact on delivery of TPA in appropriate cases. Requires historical data comparison.                                                                                              |                     |                                 |      |             |       |                      | X                 |
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Elements/Aggregated Data Elements</th>
<th>Purpose / Value</th>
<th>Outpatient Services</th>
<th>Chronic Disease Home Monitoring</th>
<th>eICU</th>
<th>ED Services</th>
<th>Admin</th>
<th>Educational Services</th>
<th>Selected Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>41. Percent change in time required for triage or evaluation in ED.</td>
<td>- Time triage or evaluation services requested&lt;br&gt;  Total&lt;br&gt;  By service type&lt;br&gt; - Time triage or evaluation services provided&lt;br&gt;  Total&lt;br&gt;  By service type</td>
<td>Provides measure of change in obtaining triage or evaluations and use of ED beds. Requires historical data comparison.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. Practitioners referring patients for telehealth: percent of total practitioners.</td>
<td>- Number of practitioners&lt;br&gt; - Number of practitioners with telehealth referrals</td>
<td>Provides an indicator of the acceptance and use of telemedicine by referring practitioners.</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>43. Percent of providers that indicated overall satisfaction levels of satisfied or above: total and by reason.</td>
<td>- Number of satisfaction instruments collected&lt;br&gt; - Number of responses that indicate satisfied or above: Total responses&lt;br&gt;  Total responses by reason.</td>
<td>Identified overall satisfaction and reasons. Reasons could include:&lt;br&gt;  - Makes efficient use of time&lt;br&gt;  - Integrated into workflow&lt;br&gt;  - Presenter knowledgeable&lt;br&gt;  - Technology is reliable&lt;br&gt;  - Technology is appropriate&lt;br&gt;  - Patient comfortable / cooperative</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>44. Percent of providers indicating unsatisfied: total and by specific reason.</td>
<td>- Number of satisfaction instruments collected&lt;br&gt; - Number of responses that indicate unsatisfied or below by reason</td>
<td>Detects provider concerns. Reasons may include:&lt;br&gt;  - Technology did not perform as expected</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Data Elements/Aggregated Data Elements</td>
<td>Purpose / Value</td>
<td>Outpatient Services</td>
<td>Chronic Disease Monitoring</td>
<td>eICU</td>
<td>ED Services</td>
<td>Admin</td>
<td>Educational Services</td>
<td>Selected Indicators</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>---------------------------</td>
<td>------</td>
<td>-------------</td>
<td>-------</td>
<td>----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>45. Percent of patients for whom Telehealth encounter were deemed appro-</td>
<td>• Total encounters</td>
<td>An indicator of referral pattern behaviors. Detects opportunities for provider</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>proved.</td>
<td>• Inappropriate encounter</td>
<td>education.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46. Percent of patients for</td>
<td>• Number of encounters where provider</td>
<td>This only applies to patient site providers that participated in teleconsult-</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>whom Telehealth encounter were deemed appropriate.</td>
<td>provider participated in the encounter</td>
<td>ion. This is a measure of effectiveness and impact.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of providers that indicated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>increased understanding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47. Percent of patient sites</td>
<td>• Number of satisfaction instruments</td>
<td>Identified overall satisfactions and reasons. Reasons could include:</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>indicating satisfied or above</td>
<td>collected</td>
<td>o Makes Efficient use of time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and by specific reason.</td>
<td>• Number of responses that indicate</td>
<td>o Integrated into workflow</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>satisfied or above and by specific</td>
<td>o Provider knowledgeable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>reason</td>
<td>o Technology is reliable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Technology is appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Patient comfortable / cooperative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Data Elements/Aggregated Data Elements</td>
<td>Purpose / Value</td>
<td>Outpatient Services</td>
<td>Chronic Disease Home Monitoring</td>
<td>eICU</td>
<td>ED Services</td>
<td>Admin</td>
<td>Educational Services</td>
<td>Selected Indicators</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>----------------------------------</td>
<td>------</td>
<td>-------------</td>
<td>--------</td>
<td>----------------------</td>
<td>---------------------</td>
</tr>
</tbody>
</table>
| 48. Percent of patients indicating unsatisfied: total and by specific reason. | - Number of satisfaction instruments collected  
- Number of responses that indicate unsatisfied or below by specific reason | Detects patient site concerns of concern. Reasons my include:  
- Technology did not perform as expected  
- Provider site not prepared  
- Proper video etiquette was not followed  
- Poor provider presentation skills  
- Necessary information unavailable  
- Ineffective use of time | X       | X       | X       | X       | X       | X        | X   |                     |
| 49. Percent of providers / presenters that are trained to use the system. | - Number of Telehealth providers/ presenters in system  
- Number that received formal training | Identifies training levels. | X       | X       | X       | X       | X       | X   |                     |
| 50. Percent of providers / presenters that demonstrate adequate ability in telehealth service delivery. | - Number of Telehealth providers/ presenters in system  
- Number that demonstrated skill in telehealth service delivery | Direct observation needs to support assessment of skills. Identifies need for additional training. | X       | X       | X       | X       | X       | X   |                     |
| **Patient Measures**                                                     |                                                                                                     |                                                                                                     |                     |                                  |      |             |        |                     |
| 51. Percent of patients that indicated overall satisfaction levels of satisfied or above. | - Number of patient responses collected  
- Number of patient responses with satisfied or above | Identifies overall satisfaction. | X       | X       | X       | X       | X       | X   |                     |
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Elements/Aggregated Data Elements</th>
<th>Purpose / Value</th>
<th>Outpatient Services</th>
<th>Chronic Disease Home Monitoring</th>
<th>eICU</th>
<th>ED Services</th>
<th>Admin</th>
<th>Educational Services</th>
<th>Selected Indicators</th>
</tr>
</thead>
</table>
| 52. Percent of patients that indicated they would recommend the telehealth system to a friend or family member | • Number of patient responses collected  
• Number of favorable patient responses | Identifies overall satisfaction. | X | X | X | X | | X | X |
| **Cost Benefit** | | | | | | | | | |
| 53. Estimated reduction or avoidance in travel costs as a result of using Telehealth system: total, by type of transport, and by payer of transport. | • Total sessions held  
• Total travel miles avoided  
   By patients  
   By providers  
   By payer  
   By service type  
• Estimated cost of travel miles  
   By patients  
   By providers  
   By payer  
   By service type | This indicator reflects all types of travel cost avoidance – both patient and provider. Should be captured with each appropriate encounter or by use of algorithm. Many programs develop algorithm to identify where provider or patient would have to travel without telehealth, determine mode of transportation and estimates costs of the transportation including: vehicle charges (personal vehicle, ambulance, public transportation, air ambulance), mileage costs, salary costs while traveling, overtime/swing shift cost etc. Payer types may include patient, health system, insurer, government program.  
Provides indicator of the environmental impact | X | X | X | X | X | X |
| 54. Carbon Footprint Impact | • Total travel miles avoided  
• Total reduction in carbon footprint | | | | | | | | |
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Elements/Aggregated Data Elements</th>
<th>Purpose / Value</th>
<th>Outpatient Services</th>
<th>Chronic Disease Home Monitoring</th>
<th>eICU</th>
<th>ED Services</th>
<th>Admin</th>
<th>Educational Services</th>
<th>Selected Indicators</th>
</tr>
</thead>
</table>
| 55. Net cost and revenue per telehealth service delivery unit: total and by service type. | **Net cost of telehealth service delivery**  
- Total cost per unit  
- Total cost per unit by service type  
**Net revenue per telehealth service delivery**  
- Total revenue per unit  
- Total revenue per unit by service type | Provides per unit cost for services provision. Requires work with the organization’s Administration and Finance offices to develop and apply a model. Organization creates model customized to specific application and situation. Data elements could include:  
- Cost of equipment  
- Amortization period  
- Cost of development  
- Staffing costs  
- Overhead  
- Insurance  
- IT support  
- Training  
- Cost of provider services, revenue – direct and indirect | x | x | x | x | x | x |
| 56. Return on Investment. | **Revenue / Gain from Investment in telehealth**  
**Cost associated with Investment in telehealth** | Measure to compare the cost of a program with the anticipated gain from the program. Requires work with the organization’s Finance Office to develop ROI model and collect data. | x | x | x | x | x | x |
<p>| 57. Cost Benefit. | <strong>List of costs by item</strong> | Overall picture of program | x | x | x | x | x | x |</p>
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Elements/Aggregated Data Elements</th>
<th>Purpose / Value</th>
<th>Selected Indicators</th>
</tr>
</thead>
</table>
| 58. Percent of total revenue generated by telehealth services NEW | - Total revenues  
- Revenue associated with telehealth service. | How telemedicine contributes to the overall revenue of the organization. May be useful to look at gross revenue and net revenue | x x x x x x x |
| 59. Percent of services reimbursed: total and service by type | - Total number of telehealth services  
  Total by type  
- Total number of reimbursed services  
  Total by type | Provides telehealth specific information on reimbursement | x x x x x x x |
| 60. Percent of total provided telehealth services that are not reimbursed. | - Total number of encounters  
- Total number of telehealth services that were reimbursed  
  Total by service type  
  Total dollar amount  
- Total number of services not reimbursed (not billed)  
  Total by service type  
  Total dollar amount | Provides information on the number of unpaid telehealth services. | x x x x x x x |
| 61. Comparative cost to put 24 hour internist | - Cost of telehealth on demand internist  
- Cost of 24 hour on-site internist | | |
| 62. Productivity loss avoided | - Estimated hours of work lost due to travel  
- Estimated cost of travel time | Requires application of an algorithm to associate time savings with productivity loss reduction. | x x x x x x x |

- List of benefits with associated financial value – can be both direct and indirect; tangible and intangible value that allows program to quantify and place a value on tangible and intangible costs and benefits.
Have you covered everything?

Take a look at the Performance Monitoring Plan. You may see some things to consider before you move on.

### Develop Performance Monitoring Plan Checklist

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You have developed an approach to measure, track, and achieve your target for telehealth volume and utilization.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. You have developed a plan to measure success in achieving your project goals, objectives and outcomes.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. You have determined how you will know what impact telehealth has made in your organization.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. You have identified data collection methods for obtaining the needed data.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. If the performance objectives are not being met, you have developed a process for identifying and implementing the necessary changes.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. You have determined how the program improvements will be defined, planned, implemented, tested, and managed.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Step Six

Implement the Telehealth Program

<table>
<thead>
<tr>
<th>Questions to Answer</th>
<th>Products and Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Are project schedules being met?</td>
<td>• Project Management Reports</td>
</tr>
<tr>
<td>• Are risks being identified and mitigated?</td>
<td>• Project Team Meeting</td>
</tr>
<tr>
<td>• Is a communication plan in place?</td>
<td>• Program deliverables</td>
</tr>
<tr>
<td>• Is work being done in a quality manner?</td>
<td></td>
</tr>
<tr>
<td>• Do any tasks need revision?</td>
<td></td>
</tr>
<tr>
<td>• Are any needed program modifications being identified and managed?</td>
<td></td>
</tr>
<tr>
<td>• Are all the deliverables and products required for operation complete?</td>
<td></td>
</tr>
<tr>
<td>• Is the program ready for operation?</td>
<td></td>
</tr>
</tbody>
</table>

Step Six ensures that everything needed to make the telemedicine program operational is completed. This step starts with ensuring that ALL the tasks required to fully implement the program are defined, scheduled, and assigned a primary resource responsible for task completion. This is the step in which program development particularly benefits from applying project management principles and practices.

Depending on the scope of the telemedicine program, the work that occurs during this step may be managed by a dedicated project manager using formal project management practices to keep the work effort on track. Smaller work efforts may be more informally managed and coordinated. In nearly all cases, it is useful to have a lead person responsible for ensuring the completion and coordination of many different tasks required to implement the program.

A detailed work plan is generally used to record and track progress on these tasks and to highlight dependencies between tasks. Once the work plan is established, focus shifts toward executing that plan in order to complete all tasks required to implement the program while keeping stakeholders updated on status, managing risks and resolving issues encountered. Once the program has moved into operation, the phase focuses on executing the performance monitoring plan and conducting the ongoing program monitoring and evaluation.

Following the plans and specifications established during Step Four, this step ensures that:
- Equipment is purchased and installed;
- Clinical protocols are finalized;
- Contracts are implemented;
- Operational processes and procedures are created or revised and communicated;
- Staff are hired or assigned;
• Staff are trained;
• Facilities are established;
• All aspects of the telemedicine program are tested (to the extent feasible) to ensure that the program is ready to begin delivering the targeted services using the envisioned Program model.

Activities

1. Project Management Reports

Step Six manages, monitors, and reports on the implementation of the program. It also includes activities related to evaluating and monitoring risks and issues and communicating progress to stakeholders. A variety of project management tools and reports are available to support the implementation including:
   • Implementation plan updates;
   • Status reports;
   • Communication plans; and
   • Test plans.

2. Project Deliverables

During Step Six all project deliverables should be accomplished. Products created during the implementation could include:
   • Finalized clinical protocols for new service;
   • Executed contracts and agreements;
   • Policies and Procedures;
   • Patient Informing Materials;
Have you covered everything?

Take a look at the below checklist. You may see some things to consider before you move on.

Implement the Telehealth Program Checklist

1. You are monitoring project schedules and determining if deliverables are being met.
   
   Yes  No  Unsure

2. You are identifying risks and mitigating when necessary.
   
   Yes  No  Unsure

3. You have implemented your communication plan.
   
   Yes  No  Unsure

4. You have determined how needed program modifications are identified and managed.
   
   Yes  No  Unsure
Step Seven

Monitor & Improve Program

<table>
<thead>
<tr>
<th>Questions to Answer</th>
<th>Products and Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is data being collected?</td>
<td>• Performance monitoring</td>
</tr>
<tr>
<td>• Are regular performance monitoring reports being produced?</td>
<td>• Improvement logs and data collection documents</td>
</tr>
<tr>
<td>• Are the reports being reviewed by the program team?</td>
<td>• Implement improvements and changes to the program</td>
</tr>
<tr>
<td>• Is the program meeting its objectives?</td>
<td></td>
</tr>
<tr>
<td>• What program changes would improve operation or outcomes?</td>
<td></td>
</tr>
<tr>
<td>• What challenges or improvements have been identified?</td>
<td></td>
</tr>
</tbody>
</table>

Step Seven is the ongoing monitoring and evaluation of your program, and the identification, assessment and implementation of program improvements. Step Seven monitors the program to determine if it is achieving the desired clinical and business outcomes. This step also identifies necessary changes or improvements. Once the program is operational, Step Seven will be repeated at intervals described in the Monitoring Plan and will become a part of regular operations.

Activities

1. Performance Monitoring

Data analysis determines whether the outcome was different from what was expected. The results and interpretation of the data analyses should be incorporated in a report and/or presentation format.

2. Improvement Logs and Data Collection Documents

Documentation is a critical step in the evaluation process. Collecting data and maintaining improvement logs will allow a program to track project deliverables and identify areas for potential improvement.
3. Implement Improvements and Changes to the Program

Based on the analysis of the data, program enhancements and modifications may need to be made. The telemedicine program will need to determine how they plan to implement the changes.

**Have you covered everything?**

Take a look at the Evaluate & Improvement Checklist. You may see some things to consider before you move on.

**Evaluate & Improve Program Checklist**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You can determine if the program is meeting its objectives.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. You can identify what changes are needed to ensure that the program meets its objectives.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
As you begin…Lessons from the field

The experiences of other telehealth programs contain some of the most valuable and important information you can have. This document contains the lessons learned and best practices identified by hundreds of telehealth programs implemented over the past decade. Their experience provides us with a compass for implementing programs in the most straightforward and cost effective way. These best practices were mined from evaluation reports of telehealth program developments funded by The California Telehealth and eHealth Center. These best practices were then reviewed by a national panel of experts, who both validated and added to this compendium. This compendium is organized by the Seven Steps identified in the CTRC Telehealth Program Developer.

Assess Service Needs and Environment

✔ Best Practice: Assess and confirm your organization’s readiness for telehealth

It is costly, time consuming and challenging to start telehealth even though it may sound easy. Organizations that perform a formal assessment of readiness have the advantage of identifying potential problems and addressing them early. They also gain a lot of support for the project by engaging people early.

Lessons from the field.....

- Be sure the program “matches the mission/vision”.
- Buying equipment is not the first step.
- You need the proper authority to successfully move forward.
- Knowing and reporting the strengths, weaknesses, opportunities and threats (SWOT) of your organization will help build the case for your program.
- Bringing the major department heads into the process early allows for easier development and acceptance of the program.
- Identify appropriate leadership team members, and bring the team together early.

✔ Best Practice: Perform A Needs Analysis

A needs analysis will help your organization to identify key unmet needs and will help you devise effective strategies and approaches to meet them. It will give you a clear understanding of the nature and scope of the unmet need, provide a sound foundation for planning, help you clarify objectives and shared expectations, improve coordination of services and resources and provide supporting structure for your program evaluation.
Lessons from the field.....

- Determine the needs you wish to meet, and how you are going to meet them. Invite clinical staff to identify service needs at both host and remote sites at patient and provider sites.
- Ensure the needs analysis is data driven.
- Recognize that the needs analysis is inseparable from the program model and the business case. It lies at the heart of sound telehealth program planning.

**Define the Program Model**

Have a clear understanding of the types of services you wish to deliver and the best and most appropriate Telehealth program model for your particular organization. Identify which services you will target, which geographical regions you will serve, what form of telehealth you will implement.

✔ **Best Practice: Develop preliminary goals and objects for service delivery**

Measurable goals and objectives will assist in selecting equipment, developing staffing, evaluating performance, creating cost estimates...in every facet of program design and development.

Lessons from the field.....

- Prioritize your service options.
- Be mindful of the size and scale of the program you are creating. Stay focused on the success of your initial few sites. Start small to help guarantee success.

✔ **Best Practice: Select the delivery model that best suits your service goals and objectives**

Understand the various forms of telehealth currently in use and ensure your choice is suited to the particular specialty services you plan to provide.

- Familiarize yourself with the different types of telehealth, and select the right kind(s) for your particular need. A ‘hybrid’ system, containing elements of each, can prove highly effective, particularly in the delivery of multi-disciplinary care.
- Create high quality, structured and layered training, and plan to provide it on an ongoing basis, at both host and remote sites.
- Keep your model in line with your organization’s vision, mission and strategic plan.
**Best Practice: Plan to incorporate Health Information Technology (HIT)**

The implementation of electronic health records and other HIT is taking place at a rapid rate. Telehealth systems should be designed and structured to support health information exchange.

Lessons from the field....

- If your organization is not currently deploying HIT methods and practices, it soon will be expected to at some level. Be mindful of this.
- There are always serious network security and privacy issues and concerns related to HIT, so it is imperative your technical leadership and legal counsel are involved in this planning from the outset.

**Best Practice: Grow your champions**

Many consider having clinical and administrative champions to lead and sustain the development of your telehealth program vision as the most important factor for success. Champions must be true agents of change within your organization and in positions to garner top level organization attention to obtain financial, technical, personnel and other resources. They must be inspirational figures, who play a key role in creating a professional and nurturing environment in which additional champions will be encouraged and developed.

Lessons from the field....

- Find champions who will enable you to achieve the level of change in attitudes and practice upon which a successful telehealth program depends.
- Ensure your champions are true agents of change, with the vision and passion to bring it about and instill it in others.
- Find equivalent champions at all participating network sites.
- Recognize that your champions are the primary advocates of your program, and that their success depends upon the full support and dedication of the entire team and the wider organization. Help them succeed.

**Best Practice: Know your geographic area**

It is important to understand the nature and norms of the locations you will be working with remotely. Service expectations can be quite different in different regions, as can medical services purchasing power, reimbursement options and access to other non-Telehealth caregivers.
Lessons from the field.....

- Go visit! There is simply no substitute for taking the time to visit your remote sites, meet your colleagues, and learn firsthand about their lives, patients, local opportunities, challenges and concerns.
- Keep communication between sites direct, clear and simple to avoid basic misunderstandings or clinical errors.
- Be aware that there may be important business and legal considerations to take into account when providing medical services over distance. This is especially true if a telehealth network is being planned that aims to provide service across state lines, or on a national basis.
- Know the ‘political geography’ of any region in which you wish to provide services. Understand the activities and interests of local providers, organizations and other local stakeholders. Their support of your program, and willingness to collaborate with you, may prove to be a deciding factor in creating a successful telehealth outreach program.

**Develop Business Case**

Cost benefit risks and opportunities need to be identified, analyzed and consolidated into a comprehensive business case report as part of program development efforts.

- **Best Practice: Perform a market analysis and write a business case report**

  The business case for initial and ongoing resource investment needs to be developed, reviewed and approved. A market analysis to determine market demand for proposed services will assist in assuring sustainability.

Lessons from the field.....

- Be sure you are clear about the effective demand for the services you are considering to provide. There can be great need for a particular specialty service in an area, but not necessarily the demand and/or purchasing power to obtain it.
- View grants as only short term ‘seed funding’. Actively seek long term sustainability from the outset. Grants may be sought to support required program expansion.
- Focus beyond the ‘here and now’. Incorporate growth into the business case report.

- **Identify and develop your revenue opportunities and fiscal estimates**

  Reimbursement is one of the most challenging areas in implementing sustainable telehealth programs. In the long run, programs require reliable and adequate revenue and reimbursement for clinical services. Programs need to look for opportunities to contract with payers, insurance companies and others to offer cost effective services.
Lessons from the field.....

- A sustainable program may require multiple revenue streams, e.g. hand in hand clinical and educational (CME) services. Ensure your program has a good patient payer mix.
- Learn from other telehealth practitioners about their reimbursement strategies and challenges. Understand general existing reimbursement methods and practices at host and remote sites. Base your program design on what already exists.
- Focus on delivery of services that are known to be sufficiently and reliably reimbursed.
- Rural health clinics and FQHCs have multiple revenue models available, and thorough research needs to be undertaken to identify that which is most appropriate for a particular service type.

**Plan Program and Technology**

**Create a detailed programmatic and technical implementation plan**

The most successful telehealth programs come as a result of careful and detailed planning and the deployment of well considered, integrated and streamlined technologies.

Lessons from the field.....

- Make sure your plan includes detailed information on timelines, deliverables and milestones, and detailed information on technical requirements and potential challenges as well as the demand and/or purchasing power to obtain it.
- Submit your plan for review by senior leadership and key stakeholders, and invite feedback, comments and open discussion.
- View your plan as a dynamic and living resource, which should be updated periodically as your program grows and programmatic circumstances change.
- Recognize that unforeseen circumstances and factors may influence your initial or ongoing planning. Be flexible in your approach, and able to make quick and effective adjustments to operational schedules and programmatic elements as necessary.

**Best Practice: Get the equipment right**

Select the right equipment for your telehealth application and delivery mode. Video equipment, communication systems, medical devices and software applications are critical equipment components. Obtain good information and advice and learn as much as you can about functionality, features and interoperability. Keep in mind that the best equipment for your program might not necessarily be the most expensive.
Lessons from the field....

- Clearly identify appropriate specifications for your devices, applications and all technical systems.
- Identify trustworthy and knowledgeable sources to guide you in your equipment choices, and to provide ongoing support. Do extensive equipment comparison to identify the best equipment for your program.
- Be mindful that technology advances quickly, and systems and applications will need upgrading and warranty renewals. There can be substantial costs involved. Be sure to budget.
- Test, test, test your equipment and connectivity before announcing or advertising your program.

✔ **Best Practice: Integrate telehealth into your operation.**

Telehealth activities should be designed to complement your standard practices and working methods, not complicate or interrupt them. Telehealth should be integrated alongside your face to face clinical activities. Telehealth examination rooms (both patient and provider sites) should be located in close proximity to the clinical staff.

Lessons from the field.....

- Plan a workflow analysis to reveal how your program fits in with standard clinical practice. Discuss necessary changes with stakeholders.
- Think of the telehealth technology as just another tool for the delivery of normal services, with the only difference being that the patient isn’t in the room with the consulting provider.
- Keep it simple.

✔ **Best Practice: Know the Law**

There are a wide range of legal and regulatory issues and requirements that must be understood and complied with when developing a telehealth program. Regulations and laws change frequently. Ensure your organization’s legal counsel is fully informed of your plans well in advance of implementation to allow time for complete legal reviews.

Lessons from the field.....

- Identify the current policies and regulations and determine the impact they may have on your program. Critical legal and regulatory areas to consider include licensure, credentialing, HIPAA and medication prescription.
- Consult with your legal counsel to consider any impacts on your organization and to ensure that you are aware of any new changes in laws and regulations.
- Realize that telehealth law is a rapidly changing area of law. Be sure your legal counsel stays closely in touch with your program expansion and development activities and plans.
**Best Practice: Plan for the availability of strong IT support at all participating locations**

Having ready access to trained and knowledgeable IT personnel and network support staff is critical to the effective running of your program. During consults or any clinical interaction taking place via the telehealth system, trained and efficient technical staff must be on hand to troubleshoot and make technical adjustments as necessary. Both equipment and network expertise is essential and staff must have appropriate authorizations to make network changes as needed. It is vital that an IT champion is identified and that the IT department is involved to provide authorization and approval of technical plans and strategies.

Lessons from the field.....

- Identify an IT champion.
- Focus on introducing IT personnel at all sites to each other. The better they know one another, the smoother your technical troubleshooting will be.
- Ensure IT personnel are fully versed in your technologies, and are authorized to work directly with network systems and settings at an organizational level.
- Familiarize all IT staff in your and your partner organizations (either working directly with your program or not) with all the systems, applications and network needs. There can be wider IT system dependencies and knock-on effects of telehealth operations that may not be apparent to you or your team until it’s too late.

**Best Practice: Plan to appoint a dedicated telehealth program manager**

No telehealth program will succeed without a dedicated, trained and efficient manager working in sync with your champions. This individual will help conceptualize and put into place all key operational and clinical elements of your program and will lay the foundation upon which all future development will be based.

Lessons from the field.....

- Appoint this individual at the very beginning of your program planning to help you design it.
- Scale this position to the size and scope of your program.
- View this individual as the ‘eyes and ears’ of your clinical and administrative champions. This individual should be directly responsible for all programmatic elements and the design of performance monitoring and evaluation strategies.

**Best Practice: Plan for system redundancy for all critical system applications and network**

Building redundancy (back up) into your telehealth architecture is a critical part of your program design. Knowing there is backup for critical technical systems and networks will go a long way in instilling confidence in your clinical staff as they undertake their telehealth activities.
• Technology can be fickle. Realizing this in advance and planning appropriate back-up for all your mission-critical systems and applications is vital. Don’t wait for your network to go down, without back-up, mid-consult.
• Don’t forget to budget for this redundancy, and include it in your business case analysis and plans.
• If costs for redundancy are prohibitive, ensure process redundancies are well planned to cover any technical failures.

**Best Practice: Plan for the development of protocols policies and procedures**

Clinical and service protocols should be adapted to the telehealth environment yet, as much as possible, retain content of non-telehealth protocols.

Lessons from the field.....

• Create protocols that are as close as possible to non-telehealth protocols. This will instill far greater comfort and confidence in your caregivers who will not feel they are doing something strange and unusual, and way out of line with their traditional practices.
• Follow standard, recognizable protocols which will lead to consistent clinical results that will be vital for your evaluations and program monitoring.

**Develop Performance Monitoring Plan**

Build systems into your program to measure and analyze program performance. In the planning stage, determine assessment methods and evaluation and strategies, and build a plan to create routine regular performance monitoring. Consider the need for formal evaluation of clinical services and operational or cost impacts

**Best Practice: Be sure to establish both short and long term performance goals**

It is easy to focus only on the short term when initially implementing your telehealth program. This can be a mistake, as you must recognize that implementing fundamental practice changes take time and will not happen overnight. Be sure to establish longer term goals as well, that consider clinical, business and financial outcomes several years into the future and movement towards programmatic self sustainability.

Lessons from the field.....

• Long range strategic planning for a telehealth program should be carried out on an ongoing basis and should include the program’s governing board.
• Plan to begin collecting vital program data from the very beginning of your program implementation.
• Determine and communicate your measures of success.
• Things take time. Be realistic in your setting of goals.
✓ Develop an evaluation and monitoring plan

Clearly determine before you begin your implementation, how you will go about evaluating your program and monitoring its performance. Considering what you should monitor, how frequently and by what methods, are critical questions to answer. Evaluation and monitoring should be shared and agreed with your network partners.

Lessons from the field....

- Monitor and evaluate all key elements of the program on a regular and ongoing basis.
- Include a range of topics in your plan, including service usage, patient and provider comfort level with particular technologies, devices and applications and cost savings analysis.
- Be sure to monitor and track ancillary or related services benefiting from your telehealth program activities, e.g. lab and blood tests performed at local clinics, staff and nursing employment etc.

✓ Best Practice: Develop a Quality Improvement Process

A clearly stated quality improvement process is important to any telehealth program. It will assist you in identifying improvements, reacting to changes in circumstances, and assessing unexpected performance.

Lessons from the field....

- Document improvement structure and clarify all improvement activities in your QI process.
- Create a written document.
- Find equivalent champions at all participating network sites.
- Develop and share your QI process before implementing the program.

Implement the Telehealth Program

✓ Best Practice: Apply known principles of successful telehealth room design. Create a convenient and effective care environment reminiscent of a traditional care environment.

The designated telehealth room should be user friendly, well equipped with reliable and appropriate technology, be comfortable for patients and apply basic principles of room design for videoconferencing applications.

Lessons from the field....

- Follow basic and standard rules for the design of your telehealth room. When designing your telehealth room space pay close attention to location, size, equipment, furniture placement, lighting acoustics and wall color.
• Plan carefully and discuss your design ideas with program colleagues and IT personnel.
• Remember to budget for necessary design/remodeling.
• Make sure that any licensing requirements are known and implemented.

✓ **Best Practice: Get the people right**

Any program stands and falls by the people implementing it. In the case of telehealth, appointing and or hiring the right staff at both the patient and the provider sites and clearly defining their roles and responsibilities, is crucial. Whenever possible, dedicated staff should be hired, who fully understand the program’s outreach goals and ambitions. The provision of effective ongoing training and personnel development is immeasurably important. Realize that further telehealth champions can be grown from your staff to lead further growth and development. Actively nurture them.

Lessons from the field.....

• Identify a coordinator to oversee all daily operational activities of the program scheduling, billing, technical operations etc. Ideally, this individual should be employed full-time on your program.
• Make sure all staff are technically savvy, knowledgeable about telehealth systems and applications, and are flexible and open to new clinical methods and approaches.
• Create an environment in which staff at both sites can work well together to create a seamless, comfortable, and reassuring clinical atmosphere for the patients.
• Share existent resources, hire additional dedicated personnel, or find staff through outsourcing activities for your program.
• Develop and implement a formal, comprehensive and standardized training regimen for all staff. Training must be ongoing and designed to increase in scope and scale as your telehealth program expands.
• Nurture further telehealth ‘champions’, from all levels of your staff.

✓ **Best Practice: Provide easy to use administrative tools**

It makes good sense to simplify tools and processes for scheduling, billing, program measurement and documentation.

Lessons from the field.....

• Keep administrative systems and methods simple! Medical administration is often complex enough without the added challenge of operating over distance and in unfamiliar administrative environments.
• Ensure administrative staff is well trained and conversant in telehealth methods and practices.
• Determine and communicate your measures of success.
• Carefully document all administrative processes and protocols.
Best Practice: Communicate regularly with your remote partners

The clinicians, nursing staff, presenter, schedulers and other staff at the site remote from you (whether you are a provider or a patient site) are the other half of your program. Ensure that both ends of the telehealth link are satisfied with the program’s management, administration, billing systems, IT support, problem resolution, coordination, and quality improvement.

Lessons from the field.....

- Consider bringing participating site personnel together quarterly or annually to discuss the program, air grievances and discuss and implement any changes necessary. This will enhance relationships and build support.
- Keep your communication channels open.
- Learn and move the program forward together.

Monitor and Improve Program

Best Practice: Implement your Quality Improvement Process

After assessing the initial performance of your program, taking into account service utilization, provider and patient satisfaction and other key factors, you should begin to implement the QI process you developed during the planning process.

Lessons from the field.....

- Evaluate the strengths and weaknesses of your program on a regular basis.
- Implement new ideas, adjustments and solutions in an organized fashion.
- Ensuring constant quality improvement must be a part of regular operations.

Best Practice: Report regularly

Regularly monitoring your program’s performance to identify trends and areas for improvement will allow the program to continuously improve and will provide the data necessary to determine if your program is achieving its objectives and to measure the program’s impact in your organization and the community.

Lessons from the field....

- General service utilization reports and quality of service measurements are of primary importance.
- Evaluate your telehealth systems and applications in a clinically appropriate and user friendly manner.
- Undertake ongoing analysis of financial performance. This will form the basis of your business strategy as you move towards self sustainability. Financial analysis should include evaluation of cost and benefits, coding issues, reimbursement, account receivables and network utilization.
**Best Practice: Present your outcomes**

In the ever expanding and increasingly mainstream field of telehealth, there is tremendous interest from around the country in program experiences and lessons learned. There are numerous opportunities to publish or present your findings and share these experiences with new and long established developers of telehealth programs and the wider community. Share what you have learned!

Lessons from the field…..

- Present your outcomes and program developments in a public forum (published or by meeting presentation) at least once per year.
- Involve members of your telehealth team in these positive communication activities. This will help secure buy-in from your staff, and increase passion for the program.
- Join forums for networking purposes, and the sharing of experiences and lessons learned.
- Share existent resources, hire additional dedicated personnel, or find staff through outsourcing activities for your program.
- Share outcomes and successes with non telehealth stakeholders and interested parties, the local communities in which you work, etc.

*And last but not least…..*
Telehealth Reimbursement Guide
For California

May 2019

Compiled by the California Telehealth Resource Center and Includes:

Medicare
Medi-Cal
Denti-Cal
CCS/GHPP
Managed Care Health Plans
FQHC/RHC Billing Scenarios

CALIFORNIA TELEHEALTH RESOURCE CENTER

Your resource for telehealth success
caltrc.org  |  877.590.8144

Part of the OCHIN Family of Companies
This document is intended as a guide to assist telehealth providers in obtaining information on reimbursement. This document does not constitute legal advice. Many factors affect the appropriateness of submitting a particular claim for reimbursement. The information should be used in consultation with your billing specialist and other advisers in initiating telehealth services billing. Reimbursement information can become outdated quickly and is subject to change without notice. We recommend review of this material on a regular basis to assure the information is up to date. Please visit www.caltrc.org to download the latest version. CTRC does not guarantee payment for any service.

The California Telehealth Resource Center is a leading source of expertise and comprehensive knowledge on the development and operation of telemedicine and telehealth programs. CTRC has received national recognition as one of fourteen federally designated Telehealth Resource Centers in the country since 2006.

This project is made possible by grant number G22RH30349 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS. This information or content and conclusions are those of the CTRC and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
INTRODUCTION

What Is Telemedicine?

Telemedicine generally refers to the provision of clinical services from a distance. The Institute of Medicine of the National Academy of Science defines telemedicine as “the use of electronic information and communication technologies to provide and support health care when distance separates the participants”. Telemedicine is a component of telehealth.

What Is Telehealth?

Telehealth is a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies.

As state and federal policymakers, private payors, practitioners, and consumers realize telehealth’s potential benefits, there is a growing need to create a consistent framework for understanding what is meant by “telehealth,” and how the term is accurately applied.

First and foremost, telehealth is a collection of means or methods, not a specific clinical service, to enhance care delivery and education. Ideally, there should not be any regulatory distinction between a service delivered via telehealth and a service delivered in person. Both should be held to the same quality and practice standards. The “tele-” descriptor should ultimately fade from use as these technologies seamlessly integrate into health care delivery systems.

While “telemedicine” has been more commonly used in the past, “telehealth” is a more universal term for the current broad array of applications in the field. Its use crosses most health service disciplines, including dentistry, counseling, physical therapy, and home health, and many other domains. Further, telehealth practice has expanded beyond traditional diagnostic and monitoring activities to include consumer and professional education.

While the State of California now uses the term “telehealth”, some providers and payor organizations still use the term “telemedicine” when referring to the provision of clinical care over a distance.

Note that while a connection exists between health information technology (HIT), health information exchange (HIE), and telehealth, neither HIE nor HIT are considered to be telehealth.
How Does Telehealth Work?

Today, telehealth encompasses four distinct domains of applications. Note, however, that each state Medicaid program and private insurer varies in its use and reimbursement of these applications. These are commonly known as:

- **Live Videoconferencing** (Synchronous): Live, two-way interaction between a person and a provider using audiovisual telecommunications technology.

- **Store-and-Forward** (Asynchronous): Transmission of images and recorded health history through an electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time or live interaction.

- **Remote Patient Monitoring** (RPM): Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider in a different location for use in care and related support.

- **Mobile Health** (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and PDAs. Applications can range from targeted text messages that promote healthy behavior to wide-scale alerts about disease outbreaks, to name a few examples.

Is Telemedicine A Billable Service?

In many cases telemedicine services are covered benefits and are billable by government programs and private payors. This guide provides information on major telemedicine reimbursement programs in California. As the field is rapidly expanding, it should be noted that more and more public, private and commercial payors may begin to cover telemedicine. It is important that you check with your major payors on a regular basis to see if additional services have been added for reimbursement. CTRC can provide updates on many of the major payors but may not be aware of all payor policies.

Reimbursement Information By Program

The following pages provide details on reimbursement for many of the major payors within the state of California.

It should be noted that telehealth is a rapidly expanding field and changes in telehealth covered services and reimbursement are expected to occur during the next few years. It will be necessary for programs to review new reimbursement provisions on a regular basis. CTRC publishes changes to reimbursement on our website and distributes them to those on the CTRC email list.

To sign up for the CTRC email list, please visit [http://caltrc.org/about-us/contact-us/](http://caltrc.org/about-us/contact-us/)
Medicare

Reimbursement for Medicare telehealth has five criteria for payment of telehealth services:

1. **The patient was seen from an “originating site” as defined by CMS.** An originating site is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Originating sites authorized by law are:
   
a. The offices of physicians or practitioners  
b. Hospitals  
c. Critical Access Hospitals (CAHs)  
d. Rural Health Clinics (RHC)  
e. Federally Qualified Health Centers (FQHC)  
f. Hospital-based or CAH-based Renal Dialysis Centers (including satellites)  
g. Skilled Nursing Facilities (SNFs) and  
h. Community Mental Health Centers (CMHCs)  
i. Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis  
j. 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. Independent Renal Dialysis Facilities are not eligible originating sites.

2. **The Originating Site is located in the following geographic areas:**
   
a. Rural Health Professional Shortage Areas (HPSAs) located in a rural census tract; and  
b. Counties located outside Metropolitan Statistical Areas (MSA),

   **Determining an eligible Originating Site location:**

   HRSA has developed a tool that will help providers determine geographic eligibility for Medicare telehealth services. This tool, the Medicare Telehealth Payment Eligibility Analyzer, is available at [https://data.hrsa.gov/tools/medicare/telehealth](https://data.hrsa.gov/tools/medicare/telehealth)

3. **The encounter was performed at the “distant site” as defined by CMS as the site where the health care provider is located.** Eligible distant site practitioners are as follows:
   
a. Physicians  
b. Nurse practitioners (NPs)  
c. Physician assistants (PAs)  
d. Nurse-midwives  
e. Clinical nurse specialists (CNSs)  
f. Certified registered nurse anesthetists  
g. Clinical psychologists (CPs) and clinical social workers (CSWs)*  
h. Registered dieticians or nutritional professionals

   **CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838**
4. **The patient was present and the encounter involved interactive audio and video telecommunications** that provides real-time communication between the practitioner and the Medicare beneficiary.

5. **Type of Service provided** as specified in the Medicare Eligible Services located in Table 1.

**Billing and Reimbursement**

**Originating Site Fee**

The originating site is eligible to receive a facility fee for providing services via telehealth. As of January 2019, the payment amount is “80% of the lesser of the actual charge or $26.15”. The site receives a flat reimbursement rate, outside of any other reimbursement arrangements such as inpatient DRGs or RHC per-visit payments.

- Originating sites are to use HCPCS code Q3014 when submitting facility fee claims.
- The type of service is 9 - other items and services.
- The place of service code is 02 - Telehealth
- Bill the MAC for the originating site facility fee, which is a separately billable Part B payment.

**Medicare provides specific instructions for different originating facility types:**

- For FQHC and RHCs: the originating site facility fee for Medicare telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.
- For Critical Access Hospitals, the payment amount is 80 percent of the originating site facility fee.
- For CMHC, the originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services.
- In addition to FQHCs, RHCs and CAHs, Chapter 12 of the Medicare Claims processing Manual, Section 190.6 describes payment methodologies for hospital outpatient departments, hospital inpatient, Physicians’ and practitioners’ offices, renal dialysis centers, skilled nursing facilities and community mental health centers.

**Distant Site Clinical Services Fees**

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

Distant site claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided. **As of January 2018, a telehealth modifier is no longer required. Instead, you will submit the appropriate CPT code and use place of service 02 – Telehealth.**

Distant site practitioners billing telehealth services under the **CAH Optional Payment Method** will continue to submit institutional claims using the GT modifier.

**NOTE:** FQHCs and RHCs are **not** authorized to serve as a distant site for telehealth consultations. A distant site is the location of the practitioner at the time the telehealth service is furnished. The cost of a visit may not be billed or included on the cost report.
The following table provides a listing of all eligible services with CPT and HCPCS codes effective January 2019. Eligible services are usually updated once a year effective in January.

**Table 1**

**Medicare Eligible Services**

<table>
<thead>
<tr>
<th>Live Interactive</th>
<th>CPT or HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth consultations, emergency department or initial inpatient</td>
<td>HCPCS codes G0425–G0427</td>
</tr>
<tr>
<td>Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs</td>
<td>HCPCS codes G0406–G0408</td>
</tr>
<tr>
<td>Office or other outpatient visits</td>
<td>CPT codes 99201–99215</td>
</tr>
<tr>
<td>Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days</td>
<td>CPT codes 99231–99233</td>
</tr>
<tr>
<td>Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days</td>
<td>CPT codes 99307–99310</td>
</tr>
<tr>
<td>Individual and group kidney disease education services</td>
<td>HCPCS codes G0420 and G0421</td>
</tr>
<tr>
<td>Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training</td>
<td>HCPCS codes G0108 and G0109</td>
</tr>
<tr>
<td>Individual and group health and behavior assessment and intervention</td>
<td>CPT codes 96150–96154</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>CPT codes 90832–90838</td>
</tr>
<tr>
<td>Telehealth Pharmacologic Management</td>
<td>HCPCS code G0459</td>
</tr>
<tr>
<td>Psychiatric diagnostic interview examination</td>
<td>CPT codes 90791 and 90792</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment</td>
<td>CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961</td>
</tr>
<tr>
<td>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 (effective for services furnished on and after January 1, 2016)</td>
<td>CPT code 90963</td>
</tr>
<tr>
<td>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 (effective for services furnished on and after January 1, 2016)</td>
<td>CPT code 90964</td>
</tr>
<tr>
<td>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 (effective for services furnished on and after January 1, 2016)</td>
<td>CPT code 90965</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older (effective for services furnished on and after January 1, 2016)</td>
<td>CPT code 90966</td>
</tr>
<tr>
<td>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 (effective for services furnished on and after January 1, 2017)</td>
<td>CPT code 90967</td>
</tr>
<tr>
<td>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 (effective for services furnished on and after January 1, 2017)</td>
<td>CPT code 90968</td>
</tr>
<tr>
<td>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 (effective for services furnished on and after January 1, 2017)</td>
<td>CPT code 90969</td>
</tr>
<tr>
<td>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 (effective for services furnished on and after January 1, 2017)</td>
<td>CPT code 90970</td>
</tr>
<tr>
<td>Individual and group medical nutrition therapy</td>
<td>HCPCS code G0270</td>
</tr>
<tr>
<td>Neurobehavioral status examination</td>
<td>CPT code 96116</td>
</tr>
<tr>
<td>Smoking cessation services</td>
<td>HCPCS codes G0436–G0437</td>
</tr>
<tr>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services</td>
<td>HCPCS codes G0396 and G0397</td>
</tr>
<tr>
<td>Annual alcohol misuse screening, 15 minutes</td>
<td>HCPCS code G0442</td>
</tr>
<tr>
<td>Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td>
<td>HCPCS code G0443</td>
</tr>
<tr>
<td>Annual depression screening, 15 minutes</td>
<td>HCPCS code G0444</td>
</tr>
<tr>
<td>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</td>
<td>HCPCS code G0445</td>
</tr>
<tr>
<td>Service Description</td>
<td>Code</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes</td>
<td>HCPCS code G0446</td>
</tr>
<tr>
<td>Face-to-face behavioral counseling for obesity, 15 minutes</td>
<td>HCPCS code G0447</td>
</tr>
<tr>
<td>Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)</td>
<td>CPT code 99495</td>
</tr>
<tr>
<td>Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)</td>
<td>CPT code 99496</td>
</tr>
<tr>
<td>Advance Care Planning, 30 minutes (effective for services furnished on and after January 1, 2017)</td>
<td>CPT code 99497</td>
</tr>
<tr>
<td>Advance Care Planning, additional 30 minutes (effective for services furnished on and after January 1, 2017)</td>
<td>CPT code 99498</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td>CPT code 90845</td>
</tr>
<tr>
<td>Family psychotherapy (without the patient present)</td>
<td>CPT code 90846</td>
</tr>
<tr>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present)</td>
<td>CPT code 90847</td>
</tr>
<tr>
<td>Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (effective for services furnished on and after January 1, 2015)</td>
<td>CPT code 99354</td>
</tr>
<tr>
<td>Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (effective for services furnished on and after January 1, 2015)</td>
<td>CPT code 99355</td>
</tr>
<tr>
<td>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) (effective for services furnished on and after January 1, 2016)</td>
<td>CPT code 99356</td>
</tr>
<tr>
<td>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) (effective for services furnished on and after January 1, 2016)</td>
<td>CPT code 99357</td>
</tr>
<tr>
<td>Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit (effective for services furnished on and after January 1, 2015)</td>
<td>HCPCS code G0438</td>
</tr>
<tr>
<td>Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit (effective for services furnished on and after January 1, 2015)</td>
<td>HCPCS code G0439</td>
</tr>
<tr>
<td>Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth (effective for services furnished on and after January 1, 2017)</td>
<td>HCPCS code G0508</td>
</tr>
<tr>
<td>Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth (effective for services furnished on and after January 1, 2017)</td>
<td>HCPCS code G0509</td>
</tr>
<tr>
<td>Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making (effective for services furnished on and after January 1, 2018)</td>
<td>HCPCS code G0296</td>
</tr>
<tr>
<td>Interactive Complexity Psychiatry Services and Procedures (effective for services furnished on and after January 1, 2018)</td>
<td>CPT code 90785</td>
</tr>
<tr>
<td>Health Risk Assessment (effective for services furnished on and after January 1, 2018)</td>
<td>CPT codes 96160 and 96161</td>
</tr>
<tr>
<td>Comprehensive assessment of and care planning for patients requiring chronic care management (effective for services furnished on and after January 1, 2018)</td>
<td>HCPCS code G0506</td>
</tr>
<tr>
<td>Psychotherapy for crisis (effective for services furnished on and after January 1, 2018)</td>
<td>CPT codes 90839 and 90840</td>
</tr>
<tr>
<td>Prolonged preventative services</td>
<td>HCPCS codes G0513-G0514</td>
</tr>
</tbody>
</table>

- Clinical psychologists (CPs) and clinical social workers (CSWs). CPs and CSWs cannot bill for codes 90792, 90833, 90836, and 90838
- For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one “hands on” visit (not telehealth) each month to examine the beneficiary’s vascular access site.
CMS Expansion of Telehealth in 2019 – Advancing Virtual Care

In 2019 CMS put forth new regulations to help advance virtual care. The intent of these regulations is to support access to care using communication technologies.

CMS will reimburse for the following:

- Opioid Use Disorder and MAT treatment
- Virtual Check-Ins
- Remote Evaluation of patient submitted photos or recorded video
- Interprofessional Internet Consultation

FQHCs and RHCs will be reimbursed for communication technology-based services and remote evaluation services that are furnished by an FQHC or RHC practitioner when there is no associated billable visit. They are not be eligible for reimbursement of Interprofessional Internet Consultations, as because the PPS includes all costs associated with a billable visit, including consultations with other practitioners.

Please note that none of these services are considered “telehealth” for CMS, therefore, they do not have the same restrictions as traditional telehealth services.

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT)

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.

Brief communication technology-based service, e.g. Virtual check-in

Virtual check-in interactions take place over telephone or live video and involve a physician or non-physician practitioner having a brief, at least five minute, check in with a patient to assess whether the patient needs to come in for an office visit.

Virtual check-ins must be for a condition that is not related to an Evaluation and Management service provided within the previous 7 days and does not lead to an Evaluation and Management Service, or procedure, in the following 24 hours or the soonest available appointment.

A practitioner may respond to the patient’s concern by telephone, audio or video, secure text messaging, email, or the use of a patient portal.

Billable providers are Physicians, Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, Clinical Psychologists, and Clinical Social Workers. If the discussion can be conducted by Nurse, Health Educator, or other clinical personnel it will not be billable as a Virtual Communication Service. Outside of an FQHC or RHC, the code billed will be G2012.

FQHCs and RHCs are allowed to bill for virtual check-ins. Virtual check-ins will be billed with code G0071.

There are no frequency limitations at this time.

Remote Evaluation Of Pre-Recorded Patient Information

Remote evaluation services consist of a practitioner evaluating an established patient’s transmitted information via pre-recorded video or image.
The service can only be billed if a condition is not related to an Evaluation and Management service provided within the previous 7 days and does not lead to an Evaluation and Management service within the following 24 hours, or the soonest available appointment.

A practitioner may respond to the patient’s concern by a telephone, audio or video, secure text messaging, email, or the use of a patient portal.

Billable providers are Physicians, Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, Clinical Psychologists, and Clinical Social Workers. If the discussion can be conducted by Nurse, Health Educator, or other clinical personnel, it would not be billable as a Remote Evaluation Service. Outside of an FQHC or RHC the code billed will be G2010.

FQHCs and RHCs are allowed to bill for remote evaluation services. The code billed will be G0071.

There are no frequency limitations at this time.

**Interprofessional Internet Consultation**

Interprofessional internet consultations covers consultations between professionals performed by a communications technology such as telephone or internet.

Verbal consent and acknowledgement of cost-sharing is required from the patient.

This service is limited to practitioners that can independently bill Medicare for Evaluation and Management visits. This is not a covered FQHC or RHC service.

The codes billed will be 99446 through 99449, 99451, and 99452.

**Remote Physiological Monitoring**

The new definition for remote patient monitoring is “a collection of physiological data (for example; ECG blood pressure glucose monitoring) digitally stored and/ or transmitted by the patient or caregiver or both to the Home Health agency”

Under this new definition remote patient monitoring will only be reimbursable when reported as a service in the provision of another skilled service.

Home visits for the purpose of supplying, or maintaining, remote patient monitoring equipment without the provision of another skilled service will not be separately billable but will constitute an allowable administrative cost under the amendments to 42 CFR 409.46.

The Remote Patient Monitoring CPT codes are as follows:

- CPT Code 99453: Remote monitoring of physiologic parameter(s) (eg, 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) (eg, 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

Additional Resources

CMS Telehealth Services Fact Sheet

CMS Federally Qualified Health Center Fact Sheet

CMS MLN Matters number: MM10583, Revised September 6, 2018

Chapter 12 of the Medicare Claims processing Manual, Section 190.6

UnitedHealthcare

Medicare Plans

UnitedHealthcare offers telemedicine and telehealth services to UnitedHealthcare Medicare patients. Telemedicine and telehealth services are covered for patients under this plan when Medicare coverage criteria are met.

Originating site requirements and allowable practitioners listed in the Medicare section of this manual apply to all telemedicine visits. UnitedHealthcare uses the same billing codes as Medicare for services.

See Medicare section of this manual for detail information on program restrictions.

Virtual Visits – HMP, EPO, POS Plans

The Virtual Visit benefit is designed to reimburse for telemedicine services rendered to a patient who is located at a location that is not a clinical Originating Site, (i.e. their home or workplace). Such services would not normally be covered under the existing telemedicine benefit. However, the addition of the Virtual Visit benefit provides coverage for those services when the member is not at a clinical Originating Site and uses a Designated Virtual Visit provider.

Conditions Required for Telehealth Use

Virtual visits are provided for the diagnosis and treatment of low acuity medical conditions. Examples include, but are not limited to:

• Bronchitis
• Seasonal Flu
• Pink Eye
• Sore Throat
• Sinus Problems

The diagnosis and treatment is provided through the use of interactive audio and visual telecommunication and transmissions and audio visual communication technology. The virtual visit must provide communication of medical information in real-time between the patient and a distant
physician or health specialist through the use of interactive audio and video communications equipment outside of a medical facility.

The virtual visit must be provided by a UnitedHealthcare Designated Virtual Network Provider. Services are currently provided by AmWell and Doctor on Demand.

Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

**Patient Consent**

Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

Nothing shall preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

Telemedicine/Telehealth services are covered only when all of the following criteria are met:

- Member requires services that are usually provided by direct contact with the provider
- Services are authorized by the member’s contracting/participating medical group or UnitedHealthcare
- The healthcare provider has determined telehealth services are appropriate
- Provider obtains verbal consent from member to provide telehealth services

**Exclusions**

This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

**Additional Resources**

United HealthCare Policy Number: BIP181.E: TELEMEDICINE/TELEHEALTH SERVICES/VIRTUAL VISITS

United HealthCare Virtual Visits FAQ
http://uhcvirtualvisits.com/FAQs
Medi-Cal Fee For Service

In-person contact between a health care provider and a patient is not required for services provided through telehealth, subject to reimbursement policies adopted by the Department of Health Care Services to compensate a licensed health care provider who provides health care services through telehealth that are otherwise reimbursable pursuant to the Medi-Cal program (Welfare and Institutions Code [W&I Code], Section 14132.72[c]).

The health care provider is not required to document a barrier to an in-person visit for Medi-Cal coverage of services provided via telehealth (W&I Code, Section 14132.72[d]).

Medi-Cal Coverage of Telehealth

**Live Interactive: Covered Service**

- A telemedicine service must use interactive audio, video or data communication to qualify for reimbursement. The E&M service must be in real-time or near real-time (delay in seconds or minutes) to qualify as an interactive two-way transfer of medical data and information between the patient and health care provider.
- The audio-video telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telemedicine. The telecommunication equipment must be of a quality to adequately complete all necessary components to document the level of service for the CPT-4 code billed. If a peripheral diagnostic scope is required to assess the patient, it must provide adequate resolution or audio quality for decision-making.
- The health care provider who has the ultimate responsibility for the care of the patient must be licensed in the State of California and enrolled as a Medi-Cal provider.
- All medical information transmitted during the delivery of health care via telemedicine must become part of the patient’s medical record maintained by the licensed health care provider.

**Store and Forward: Limited to Ophthalmology and Dermatology**

Store and forward is defined as an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site, where the physician at the distant site reviews the medical information without the patient being present in real-time. Store and forward teleophthalmology and teledermatology is a medical service separate from an interactive telemedicine consultation and must meet the following requirements:

- The images must be specific to the patient’s condition and adequate for meeting the procedural definition of the national code that is billed.
- Teleophthalmology and teledermatology by store and forward must be rendered by a physician who has completed training in an Accreditation Council for Graduate Medical Education (ACGME)-approved residency in ophthalmology or dermatology respectively.
- A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician consulted through store and forward, upon request. If requested, communication with the distant specialist physician may occur either at the time of consultation or within 30 days of the patient’s notification of the results of the consultation.
Exclusions

A telephone conversation, email, fax are not considered live interactive or Store and forward telehealth visits and are specifically excluded from the definition of telemedicine.

Conditions Required for Telehealth Use

Patient Consent – Live Video

The health care provider at the originating site must first obtain oral consent from the patient prior to providing service via telehealth and shall document the oral consent in the patient’s medical record, including the following:

- A description of the risks, benefits and consequences of telemedicine
- The patient retains the right to withdraw at any time
- All existing confidentiality protections apply
- The patient has access to all transmitted medical information
- No dissemination of any patient images or information to other entities without further written consent

Patient Consent – Store and Forward

The health care provider shall comply with the informed consent provision of Section 2290.5 of the Business and Professions Code when a patient receives teleophthalmology and teledermatology by store and forward.

Eligible Originating Sites (Patient Site)

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the patient or by the health care provider is not limited (W&I Code Section 14132.72(e)).

Eligible Distant Site Practitioners (Provider Site)

No restrictions on types or locations; however, requires licensure in State of California, enrollment as a Medi-Cal Provider, and adherence to licensure scope of practice. In addition, the distant (provider) site is only a billable visit if it meets all the requirements of the Medi-Cal program.

Billing and Reimbursement

Modifiers

Only services rendered from the distant site are billed with modifiers. Claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided and one of the following Telemedicine modifiers:

- GT or 95 for interactive audio and video telecommunications system (live interactive) or
- GQ for Store and forward applications.

Originating Site Fee

The originating site is eligible to receive a facility fee for providing services via telehealth. As of January 2018, the site facility fee is $22.94. Sites are instructed to use HCPCS code Q3014 when submitting facility fee claims. Sites fee are limited to once per day, same recipient, same provider.
Transmission Fee: Live Interactive

Medi-Cal allows payment of transmission costs associated with live interactive services. This fee can be paid to originating and distant sites. It is limited to a maximum of 90 minutes per day, same recipient, and same provider. One unit of service is equal to one minute of transmission cost.

Sites are instructed to use code T1014: telehealth transmission, per minute. As of January 2018 the transmission fee is $0.24 per minute.

Clinical Fees: Live Interactive

Table 2 provides a listing of all eligible live interactive services with CPT and HCPCS codes

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT and HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or Other Outpatient Visit – new or established patient</td>
<td>99201 – 99215</td>
</tr>
<tr>
<td>Initial Hospital Care or Subsequent Hospital Care – new or established patient</td>
<td>99231 – 99233</td>
</tr>
<tr>
<td>Consultations – office or other outpatient, initial or follow-up inpatient, and confirmatory</td>
<td>99241 – 99255</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Evaluation with and without medical services</td>
<td>90791 and 90792</td>
</tr>
<tr>
<td>Psychotherapy, 30 and 60 minute, with patient</td>
<td>90832 and 90837</td>
</tr>
<tr>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services</td>
<td>90863</td>
</tr>
<tr>
<td>Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth</td>
<td>G0508</td>
</tr>
<tr>
<td>Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth</td>
<td>G0509</td>
</tr>
</tbody>
</table>

Clinical Fees: Store and Forward

Table 3 provides a listing of all eligible store and forward services with CPT and HCPCS codes

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit</td>
<td>99211 – 99214</td>
</tr>
<tr>
<td>Subsequent hospital care</td>
<td>99231 – 99233</td>
</tr>
<tr>
<td>Office consultation, new or established patient</td>
<td>99241 – 99243</td>
</tr>
<tr>
<td>Initial inpatient consultation</td>
<td>99251 – 99253</td>
</tr>
</tbody>
</table>

A beneficiary receiving telehealth services by store and forward may also request to have real-time communication with the distant site provider at the time of the consultation or within 30 days of the original consultation.

Additional Resources

Medi-Cal Telemedicine Guidelines

Medi-Cal & Telehealth: Resources
http://www.dhcs.ca.gov/programpart/Pages/Telehealth.aspx
Denti-Cal Services

Effective July 2015, The Department of Health Care Services has opted to permit the use of teledentistry as a modality for the provision of select dental services. Therefore, enrolled Denti-Cal billing providers may submit documents for services rendered utilizing teledentistry.

*Please note that allied dental professionals, such as Registered Dental Hygienists in Alternative Practice, shall not be permitted to bill for services rendered via teledentistry*

Billing and Reimbursement

Providers may use CDT Code D9999 for reimbursement of live transmission costs associated with teledentistry (D0999). When submitting a claim for reimbursement of live transmission costs, CDT Code D9999 will only be payable when CDT Code D0999 has been rendered. The reimbursed rate is 24 cents per minute, up to a maximum of 90 minutes. Procedure D9999 may only be used once per date of service per beneficiary, per provider. Written documentation is required and must include the number of minutes the transmission occurred.

Teledentistry claims are identified using Current Dental Terminology (CDT) code D0999 (“Unspecified diagnostic procedure, by report”) with a date of service on or after July 1, 2015. As of October 2018, the Schedule of Maximum Allowance (SMA) for D0999 used for teledentistry is $46.00.

Live transmissions are only billable at the beneficiary’s request. If the live transmission cannot occur at the precise time of the beneficiary request, then a subsequent agreed upon time may be scheduled between the beneficiary and provider within a 30 day time period.

Table 4 provides a listing of all eligible live interactive services with CPT codes.

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unspecified diagnostic procedure, by report</td>
<td>D0999</td>
</tr>
<tr>
<td>Transmission Fee</td>
<td>D9999</td>
</tr>
</tbody>
</table>

**Clinical Fees: Store and Forward**

Teledentistry claims are identified using Current Dental Terminology (CDT) code D0999 (“Unspecified diagnostic procedure, by report”) with a date of service on or after July 1, 2015. As of October 2018, the Schedule of Maximum Allowance (SMA) for D0999 used for teledentistry is $46.00.

Providers may bill for teledentistry on the same claim form as other types of procedure codes unless they are in conflict with the Denti-Cal Manual of Criteria (MOC).

*A beneficiary receiving teledentistry services by store and forward may also request to have real-time communication with the distant dentist at the time of the consultation or within 30 days of the original consultation.*
Table 5 provides a listing of all eligible store and forward services with CPT codes effective 2018

### Table 5
**Denti-Cal Eligible Telemedicine Services**
**Store and Forward**

<table>
<thead>
<tr>
<th>Service</th>
<th>CDT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unspecified diagnostic procedure, by report</td>
<td>D0999</td>
</tr>
<tr>
<td>Periodic oral evaluation — established patient</td>
<td>D0120</td>
</tr>
<tr>
<td>Comprehensive oral evaluation – new or established patient</td>
<td>D0150</td>
</tr>
<tr>
<td>Intraoral — complete series of radiographic images</td>
<td>D0210</td>
</tr>
<tr>
<td>Intraoral — periapical first radiographic image</td>
<td>D0220</td>
</tr>
<tr>
<td>Intraoral — periapical each additional radiographic image</td>
<td>D0230</td>
</tr>
<tr>
<td>Intraoral — occlusal radiographic image</td>
<td>D0240</td>
</tr>
<tr>
<td>Bitewing — single radiographic image</td>
<td>D0270</td>
</tr>
<tr>
<td>Bitewings — two radiographic images</td>
<td>D0272</td>
</tr>
<tr>
<td>Bitewings — four radiographic images</td>
<td>D0274</td>
</tr>
<tr>
<td>Panoramic radiographic image</td>
<td>D0330</td>
</tr>
<tr>
<td>Oral/Facial photographic images</td>
<td>D0350</td>
</tr>
</tbody>
</table>

### Additional Resources

**Denti-Cal Quick Reference Guide**

**Denti-Cal Teledentistry Tutorial**
[https://www.denti-cal.ca.gov/DC_media/providers/teledentistry_tutorial.mp4](https://www.denti-cal.ca.gov/DC_media/providers/teledentistry_tutorial.mp4)
California Children’s Services (CCS) and Genetically Handicapped Persons Program (GHPP)

CCS and GHPP programs follow Medi-Cal policies and procedures concerning coverage and reimbursement of telemedicine services.

Table 6 provides a listing of all eligible live interactive services with CPT codes.

<table>
<thead>
<tr>
<th>Service</th>
<th>CDT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tympanometry and reflex threshold measurements</td>
<td>92550</td>
</tr>
<tr>
<td>Acoustic reflex testing, threshold/unlisted audiologic services</td>
<td>92568</td>
</tr>
<tr>
<td>Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system/limited/unlisted aud. services</td>
<td>92586</td>
</tr>
<tr>
<td>Evoked optoacoustic emissions, limited/unlisted audiologic services</td>
<td>92587</td>
</tr>
<tr>
<td>Evoked optoacoustic emissions, comprehensive or diagnostic evaluation/unlisted audiologic services</td>
<td>92588</td>
</tr>
<tr>
<td>Office or Other Outpatient Visit – new or established patient</td>
<td>99201-99215</td>
</tr>
<tr>
<td>Genetics counseling</td>
<td>S0265</td>
</tr>
<tr>
<td>Physical therapy evaluation, approval from PT, first 30 minutes and add 15 min</td>
<td>X3920-X3922</td>
</tr>
<tr>
<td>Occupation therapy evaluation, first 30 minutes and add 30 min</td>
<td>X4100-X4102</td>
</tr>
<tr>
<td>Speech therapy language and speech evaluation plus report</td>
<td>X4300-X4302</td>
</tr>
<tr>
<td>Speech-language therapy, individual, per hour (following procedures X4300 or X4301)</td>
<td>X4303</td>
</tr>
<tr>
<td>Speech-language therapy, individual, 1/2 hour</td>
<td>X4304</td>
</tr>
<tr>
<td>Center coordinator, non-physician, case, registered dietician</td>
<td>Z4300</td>
</tr>
<tr>
<td>Assessment, intervention, with instruction, ed., nurse specialist</td>
<td>Z4301</td>
</tr>
<tr>
<td>Team case conference, other allied health care professional</td>
<td>Z4302</td>
</tr>
<tr>
<td>Physician SCC chart review, intermediate</td>
<td>Z4303</td>
</tr>
<tr>
<td>Physician, extensive/comprehensive visit</td>
<td>Z4304</td>
</tr>
<tr>
<td>Physician visit, per patient/per date of service</td>
<td>Z4305</td>
</tr>
<tr>
<td>Physician/Dentist coordinating activity</td>
<td>Z4306</td>
</tr>
<tr>
<td>Social Worker, comprehensive assessment/intervention, 30 minutes.</td>
<td>Z4307</td>
</tr>
<tr>
<td>Registered Dietitian, comprehensive assessment/intervention, 30 minutes</td>
<td>Z4308</td>
</tr>
<tr>
<td>Other Allied Health Professional, comprehensive assessment/intervention, 30 min</td>
<td>Z4309</td>
</tr>
<tr>
<td>Nurse Specialist, participation SCC team case conference, 15 minutes</td>
<td>Z4310</td>
</tr>
<tr>
<td>Social Worker, SCC comprehensive team case conference, 15 minutes</td>
<td>Z4311</td>
</tr>
<tr>
<td>Registered Dietitian, SCC comp. team case conference, 15 minutes</td>
<td>Z4312</td>
</tr>
<tr>
<td>Physician, Group Teaching, counseling, &amp; support</td>
<td>Z4313</td>
</tr>
<tr>
<td>Other Allied Health Professional, Group Teaching, counseling &amp; support</td>
<td>Z4314</td>
</tr>
<tr>
<td>Physician/parent conference</td>
<td>Z4315</td>
</tr>
<tr>
<td>Allied Prof. NEC-Program/Clinical Consult.-Hr</td>
<td>Z5408</td>
</tr>
<tr>
<td>Program consultation/Clinic (Med) – Hr.</td>
<td>Z5422</td>
</tr>
<tr>
<td>EPSDT Services – Initial audiology evaluation, &lt; 2 years of age and 2-5 years of age</td>
<td>Z5900-Z5902</td>
</tr>
<tr>
<td>PSDT Services – Auditory brainstem response, tone burst</td>
<td>Z5914</td>
</tr>
<tr>
<td>EPSDT Services – Acoustic immittance testing, monaural and binaural, including tympanometry and acoustic reflex testing</td>
<td>Z5922-Z5924</td>
</tr>
<tr>
<td>EPSDT Services – Evoked optoacoustic emissions, comprehensive or diagnostic evaluation (comparison of transient and/or distortion)</td>
<td>Z5934-Z5936</td>
</tr>
<tr>
<td>EPSDT Services – Aural rehabilitation related to use of a conventional hearing aid, 30 minutes</td>
<td>Z5940</td>
</tr>
<tr>
<td>EPSDT Services – Aural rehabilitation following cochlear implantation, 30 minutes</td>
<td>Z5942</td>
</tr>
</tbody>
</table>

Additional Resources

CCS Numbered Letter No. 14-123 Telehealth Services for CCS and GHPP Programs

CCS Numbered Letter No. 16-1217 Telehealth Services Code Update for CCS and GHPP Programs.
https://www.dhcs.ca.gov/services/ccs/Documents/ccsnl161217.pdf
Anthem Blue Cross Telehealth Programs

Anthem Blue Cross has telehealth services available through a variety of programs administered and operated by Anthem Blue Cross. This section outlines the Anthem Blue Cross Telehealth Program provisions and benefits.

**Anthem Blue Cross Coverage of Telehealth**

- Live interactive
- Store and forward

In order for telehealth services to be eligible for reimbursement, the provider’s services must be rendered from one of the following locations:

a. Provider’s office  
b. Hospital  
c. Rural Health Clinic  
d. Federally Qualified Health Center  
e. Other location with prior plan approval

Service benefits are consistent across all programs with the exceptions below.

**Conditions Required for Telehealth Use**

*Verbal and Written Patient Consent*

All telehealth encounters require that verbal informed consent be obtained and documented by the Originating Site. This documentation is part of the medical record to be kept with other documentation.

**Exclusions**

A telephone conversation, email, fax are not considered live interactive or store and forward telehealth visits and are specifically excluded from the definition of telemedicine.

**Eligible Member Populations**

- a. Anthem Blue Cross Medi-Cal Managed Care Plans  
- b. CalPERS Basic Plan  
- c. Butte Schools Self-funded Program  
- d. California’s Valued Trust (CVT)  
- e. Self-Insured Schools of California (SISC)  
- f. University of California (UC)

**Eligible Originating and Distant Sites**

Anthem Blue Cross limits participation in its telemedicine program to members of the Blue Cross Open Access Network. All originating (patient) and distant (provider) sites must be a member of this network.

**Billing and Reimbursement**

Anthem Blue Cross of California uses standardized billing procedures when submitting claims.
Modifiers
To be used by the distant site

- GT for live interactive telemedicine encounters
- GQ for store and forward telemedicine encounters

Originating Site Fee – Live Video
Specialty Sites may not bill for an originating site fee.

Originating Site Fee – Store and Forward
Presenting sites serving eligible Medi-Cal members may bill site fees for store and forward consults.

Table 7
Anthem Blue Cross Eligible Telemedicine Services
Site Fee Billing Codes

<table>
<thead>
<tr>
<th>Live Interactive</th>
<th>Presentation Site</th>
<th>Specialty Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Interactive</td>
<td>CMS-1500 Q3014</td>
<td>G9002</td>
</tr>
<tr>
<td></td>
<td>CMS-1450 Q3014</td>
<td>G9002</td>
</tr>
<tr>
<td>Store and Forward</td>
<td>CMS-1500 Q3014</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>CMS-1450 Q3014</td>
<td></td>
</tr>
</tbody>
</table>

Transmission Fees

- Anthem Blue Cross will pay claims for Blue Cross members’ telecommunication charges for live interactive consultations only.
- Only the site that initiates the live interactive telemedicine encounter may bill. Table 7 below shows the appropriate codes
- Each minute (or part thereof) is equal to one (1) unit of occurrence with a maximum of 90 minutes of occurrence (1.5 hours billable maximum).

Table 8
Anthem Blue Cross Eligible Telecommunications Codes

<table>
<thead>
<tr>
<th>Program</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Medical Services Program, Healthy Families, Path2Health Medi-Cal</td>
<td>T1014-GT</td>
</tr>
</tbody>
</table>

Clinical Fees: Live Interactive
Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

Table 9 provides a listing of all eligible live interactive services with CPT codes, effective 2018.
Table 9
Anthem Blue Cross Eligible Telemedicine Services
Live Interactive

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Providers</strong></td>
<td></td>
</tr>
<tr>
<td>New patient office visit</td>
<td>99201-99205</td>
</tr>
<tr>
<td>Established patient office visit</td>
<td>99211-99215</td>
</tr>
<tr>
<td><strong>Specialist</strong></td>
<td></td>
</tr>
<tr>
<td>Consultations</td>
<td>99241-99245</td>
</tr>
<tr>
<td>Follow-up visits</td>
<td>99211-99215</td>
</tr>
<tr>
<td><strong>Psychiatry</strong></td>
<td></td>
</tr>
<tr>
<td>Psychiatric diagnosis</td>
<td>90801-90809</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>90810-90815</td>
</tr>
<tr>
<td>Individual psychotherapy (inpt)</td>
<td>90816-90819</td>
</tr>
<tr>
<td>Individual psychotherapy (inpt)</td>
<td>90821-90829</td>
</tr>
<tr>
<td>Medical psychoanalysis</td>
<td>90833</td>
</tr>
<tr>
<td>Pharmacological psychiatric mgt</td>
<td>90862</td>
</tr>
<tr>
<td>Consultations</td>
<td>99241-99245</td>
</tr>
<tr>
<td>Established member office visits</td>
<td>99211-99215</td>
</tr>
</tbody>
</table>

**Clinical Fees: Store and Forward**

Anthem Blue Cross pays for claims for the review of patient files for store and forward under codes:

- 99241-99245 Consultants

The preparation of the store and forward consult should be billed as part of the primary care provider’s office visit.

Store and forward is accomplished via secured email communication. As such, there are no telecommunication charges applicable. Therefore, there is no telecommunication reimbursement offered by Anthem Blue Cross.

**Live Health Online (LHO)**

LiveHealth Online (LHO) is a website and mobile application that gives patients 24/7 access to on-demand video visits (medical). It has an urgent care focus and provides convenient access anytime, anywhere in California, even at home, via smartphone, tablet or computer.

LHO connects patients with board-certified physicians supporting physical and behavioral health. Physicians can electronically prescribe to the member’s pharmacy.

*Note: Only noncontrolled substances can be prescribed.*

It is available at no cost for Anthem Blue Cross (Anthem) members enrolled in Medi-Cal Managed Care (Medi-Cal) beginning September 1, 2018.

**Additional Resources**

Anthem Blue Cross: Telemedicine Program Provider Operations Manual

Anthem Blue Cross Telemedicine Website
http://w2.anthem.com/bcc_state/tm/info/index.asp
California Health & Wellness

This section outlines the California Health & Wellness Telehealth Program provisions and benefits.

California Health & Wellness Coverage of Telehealth

- Live interactive
- Store and forward

Conditions Required for Telehealth Use

**Verbal and Written Patient Consent**

Prior to each encounter of the delivery of health care services via telehealth, the licensed provider at the originating site must verbally inform the member that telehealth may be used and obtain verbal or written consent from the member. The verbal or written consent must be documented in the member’s medical record, including the following elements:

a. A description of the risks, benefits, and consequences of telemedicine
b. The member retains the right to withdraw at any time
c. All existing confidentiality protections apply
d. The member has access to all transmitted medical information
e. No dissemination of any member images or information to other entities without further written consent

**Store and Forward Patient Consent**

The health care provider shall comply with the informed consent provision of Section 2290.5 of the Business and Professions Code when a member receives teleophthalmology and teledermatology by store and forward.

Members receiving teledermatology or teleophthalmology services by store and forward must be notified of the right to interactive communication with the distant specialist if requested. If requested, the communication may occur at the time of the consultation or within 30 days of the member’s notification of the results of the consultation.

Exclusions

Telehealth does not include email, telephone (voice only), text, inadequate resolution video, written communication between the providers, or between patients and providers.

Eligible Member Populations

Live interactive (synchronous) telehealth services can be provided to Plan members by any Plan-credentialied licensed provider.

Store and forward (asynchronous) telehealth services can be provided to Plan members by any Plan-credentialied licensed provider. The following licensed providers may provide store and forward services:

- a. Ophthalmologists
- b. Dermatologists
- c. Optometrists (licensed pursuant to Chapter 7 (commencing with Section 3000 of Division 2 of the Business and Professions Code)
Eligible Originating and Distant Sites

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the member or by the licensed provider is not limited (Welfare and Institutions Code [W&I Code], Section 14132.72[e]).

Billing and Reimbursement

California Health and Wellness uses standardized billing procedures when submitting claims.

Modifiers
To be used by the distant site

- GT for live interactive telemedicine encounters
- GQ for store and forward telemedicine encounters

Originating Site Fee – Live Video and Store and Forward

Q3014 - May be billed with or without a provider present

Transmission Fees

T1014 - (per minute for a maximum of 90 minutes per day, same recipient, same provider). Each minute (or part thereof) is equal to one (1) unit of occurrence.

Telehealth Models

There are two synchronous models of telehealth services available to Plan members.

a. Live interactive (synchronous) telehealth services, connects the patient with a distant licensed provider through audio-video equipment on a real-time basis.

b. Live interactive (synchronous) patient to provider telehealth services, connects a single licensed provider (primary care or specialty provider) to a member using audio-visual equipment on a real-time basis. The member can be in a health facility, residential group home or private residence or other setting, provided the appropriate equipment is used.

Table 10 provides a listing of all eligible live interactive services with CPT codes.

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit (new or established patient)</td>
<td>99201-99215</td>
</tr>
<tr>
<td>Initial hospital care or subsequent hospital care (new or established patient)</td>
<td>99221-99233</td>
</tr>
<tr>
<td>Consultations: Office or other outpatient, initial or follow-up inpatient, and</td>
<td>99241-99275</td>
</tr>
<tr>
<td>Interactive complexity (List separately in addition to the code for primary)</td>
<td>90785</td>
</tr>
<tr>
<td>Psychiatric diagnostic evaluation</td>
<td>90791</td>
</tr>
<tr>
<td>Psychiatric diagnostic evaluation with medical services</td>
<td>90792</td>
</tr>
<tr>
<td>Psychotherapy, 30 minutes with patient/or family member</td>
<td>90832</td>
</tr>
<tr>
<td>Psychotherapy, 45 minutes with patient/or family member</td>
<td>90834</td>
</tr>
<tr>
<td>Psychotherapy, 60 minutes with patient/or family member</td>
<td>90837</td>
</tr>
<tr>
<td>Psychotherapy for crisis; first 60 minutes</td>
<td>90839</td>
</tr>
<tr>
<td>Additional 30 minutes</td>
<td>90840</td>
</tr>
<tr>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy</td>
<td>90863</td>
</tr>
</tbody>
</table>
Clinical Fees: Store and Forward

Asynchronous telehealth services or store and forward services, connects a member with a distant licensed provider of ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally an image or picture is taken and forwarded to the distant licensed provider to review at a later time.

Table 11 provides a listing of all eligible store and forward services with CPT codes.

Table 11
California Health and Wellness Telemedicine Services
Store and Forward

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office consultation, new or established patient</td>
<td>99241-99243</td>
</tr>
<tr>
<td>Initial inpatient consultation</td>
<td>99251-99253</td>
</tr>
<tr>
<td>Office or other outpatient visit</td>
<td>99211-99214</td>
</tr>
<tr>
<td>Subsequent hospital care</td>
<td>99231-99233</td>
</tr>
<tr>
<td>Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists (should not be used if the originating site is submitting claims with this code)</td>
<td>92259</td>
</tr>
</tbody>
</table>

Additional Resources

California Health & Wellness Telehealth Policy
Central California Alliance for Health

This section outlines the Central California Alliance for Health (CCAH) Telehealth Program provisions and benefits. The goal of telehealth with the Alliance is to improve both access and quality health services provided in rural and other medically underserved areas through the use of information and telecommunications technologies.

In order to ensure members have sufficient access to care, especially in specialties and regions in which access is limited, the Alliance supports the use of telehealth when appropriate for the provision of these services.

Central California Alliance for Health Coverage of Telehealth

- Live interactive
- Store and forward

Conditions Required for Telehealth Use

Verbal and Written Patient Consent
The health care provider at the originating site must inform the member that telehealth services will be used and obtain the member’s verbal or written consent, which will be documented in the member’s medical record. The health care provider will disclose to enrollees the use of telehealth in the delivery of specialty or other care and, if applicable, directions for how enrollees can elect to use telehealth services for their care.

Store and Forward Patient Consent
In situations when the asynchronous store and forward system is used, members must be notified of their right to have interactive communication with the distant specialist at the time of the consultation or within 30 days of the patient’s notification of the results of the consultation. In all circumstances, providers will abide by HIPAA laws, including not disclosing a member’s personal health information to any third party without written consent.

Exclusions

The Alliance will not reimburse under this policy for routine e-mail, telephone (voice only), text, written communication between providers or between members and providers, or images with inadequate resolution.

Eligible Member Populations

Live interactive (synchronous) telehealth services can be provided to Alliance members by any Alliance credentialed health care provider with the member’s verbal consent, as documented in the patient’s medical record.

Store and forward (asynchronous) telehealth services provides for the review of medical information at a later time by a physician or optometrist at a distant site without the patient being present in real time.

Eligible Originating and Distant Sites

a. a physician office
b. clinic setting
Billing and Reimbursement

The Alliance uses standardized billing procedures when submitting claims.

**Modifiers**

To be used by the distant site

- GT for Live Interactive telemedicine encounters
- GQ for Store and forward telemedicine encounters

**Originating Site Fee – Live Video and Store and Forward**

For the originating site, a licensed provider must be present if the provider fee and site facility fee are to be reimbursable. If a licensed provider is not present at the originating site, only a site facility fee may be billed for the visit. The scope of the interaction of the originating provider must be documented in the member’s medical record. The scope of the visit should determine the codes used for billing. For lines of business that require a copay for direct patient care services, the payment will be collected at the time of the member’s visit to the originating site.

**Transmission Fees**

Transmission cost fees may be billed whether or not a licensed provider is present.

**Managed Behavioral Health Organization (MBHO)**

The Alliance contracts with a Managed Behavioral Health Organization (MBHO) to provide mild to moderate mental health services and BHT for eligible members with ASD from licensed/certified behavioral health providers as defined by Health & Safety Code Section 1374(c)(3).

Table 12 provides a listing of all eligible live interactive services with CPT codes.

**Table 12**

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit (new or established patient)</td>
<td>99201-99215</td>
</tr>
<tr>
<td>Initial hospital care or subsequent hospital care, critical care (new or established patient)</td>
<td>99221-99233, 99291, 99292</td>
</tr>
<tr>
<td>Extended Inpatient Care</td>
<td>99356 – 99357</td>
</tr>
<tr>
<td>Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory</td>
<td>99241-99275</td>
</tr>
<tr>
<td>Genetic Counseling</td>
<td>96040, 50265</td>
</tr>
<tr>
<td>Nutrition Counseling per PHC Guidelines (See Policy MCUP3052)</td>
<td>97802, 97803, 97804, 99539</td>
</tr>
<tr>
<td>Interactive complexity (List separately in addition to the code for primary)</td>
<td>90785</td>
</tr>
<tr>
<td>Psychiatric diagnostic evaluation</td>
<td>90791</td>
</tr>
<tr>
<td>Psychiatric diagnostic evaluation with medical services</td>
<td>90792</td>
</tr>
<tr>
<td>Psychotherapy, 30 minutes with patient/or family member</td>
<td>90832</td>
</tr>
<tr>
<td>Psychotherapy, 45 minutes with patient/or family member</td>
<td>90834</td>
</tr>
<tr>
<td>Psychotherapy, 60 minutes with patient/or family member</td>
<td>90837</td>
</tr>
<tr>
<td>Psychotherapy for crisis; first 60 minutes</td>
<td>90839</td>
</tr>
<tr>
<td>Additional 30 minutes</td>
<td>90840</td>
</tr>
</tbody>
</table>
Clinical Fees: Store and Forward

Store and forward (asynchronous) services, connects a member with a distant licensed provider of ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally an image or picture is taken and forwarded to the distant licensed provider to review at a later time. The following Medi-Cal certified health care providers may provide store and forward services:

a. Ophthalmologists
b. Dermatologists
c. Optometrists (licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code)
d. Specialists participating in PHC’s eConsult Program

Table 13 provides a listing of all eligible store and forward services with CPT codes.

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit (new or established patient)</td>
<td>99201-99215</td>
</tr>
<tr>
<td>Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory</td>
<td>99241-99243, 99231-99233</td>
</tr>
<tr>
<td>eConsult, electronic consultation</td>
<td>99444</td>
</tr>
<tr>
<td>Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists</td>
<td>92250</td>
</tr>
<tr>
<td>Originating Site Fee</td>
<td>Q3014</td>
</tr>
<tr>
<td>Transmission Fee</td>
<td>T1014</td>
</tr>
</tbody>
</table>

Additional Resources

CCAH Provider Manual

CCAH Provision of Telehealth Services to Alliance Members Policy 404-1727
Partnership HealthPlan of California

This section outlines the Partnership HealthPlan of California (Partnership) Telehealth Program provisions and benefits. The goal of telehealth with Partnership is to improve both access and quality health services provided in rural and other medically underserved areas through the use information and telecommunications technologies.

Partnership fully supports the advancement of telehealth services in their regions as a means of improving access and quality of care to members as well as providing expert advice and specialty consultation to primary care providers (PCPs) in the Partnership network. The effective date of this policy is for dates of service on or after March 1st, 2012. Current Partnership referral and authorization requirements apply to telehealth services per policy MCUP3124 Referral to Specialists (RAF) Policy.

Telemedicine services may also be used to provide mild-moderate severity Mental Health Services to Partnership members. Such services are provided through Partnership’s contracted Behavioral Health Managed Services organization.

**Partnership Coverage of Telehealth**

- Live interactive
- Store and forward

**Conditions Required for Telehealth Use**

*Verbal and Written Patient Consent*

Prior to the delivery of health care services via telehealth, the health care provider at the originating site must verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. The verbal consent must be documented in the patient’s medical record.

*Store and Forward Patient Consent*

Members receiving teledermatology or teleophthalmology services by store and forward must be notified of the right to interactive communication with the distant specialist if requested. If requested, the communication may occur at the time of the consultation or within 30 days of the member’s notification of the results of the consultation.

**Exclusions**

Telehealth does not include email, telephone (voice only), text, inadequate resolution video, written communication between the providers, or between patients and providers.

**Eligible Member Populations**

Live interactive (synchronous) telehealth services can be provided to Partnership members by any PHC credentialled health care provider with the member’s verbal consent, as documented in the patient’s medical record.

Store and forward (asynchronous) telehealth services provides for the review of medical information at a later time by a physician or optometrist at a distant site without the patient being present in real time.
The following Medi-Cal certified health care providers may provide store and forward services:
   a. Ophthalmologists
   b. Dermatologists
   c. Optometrists [licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code]
   d. Specialists participating in PHC’s eConsult Program

**Eligible Originating and Distant Sites**

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the member or by the licensed provider is not limited (Welfare and Institutions Code [W&I Code], Section 14132.72[e]).

**Billing and Reimbursement**

Partnership uses standardized billing procedures when submitting claims.

**Modifiers**

To be used by the distant site
   - GT for live interactive telemedicine encounters
   - GQ for store and forward telemedicine encounters

**Originating Site Fee – Live Video and Store and Forward**

Q3014 – May be billed without a provider present

**Transmission Fees**

T1014 - (per minute for a maximum of 90 minutes per day, same recipient, same provider). Each minute (or part thereof) is equal to one (1) unit of occurrence.

**Telehealth Models**

There are two synchronous models of telehealth services available to Plan members.
   a. Live interactive (synchronous) Telehealth Services connects the patient with a distant provider of health services through audio-video equipment on a real-time basis. This model is commonly used between specialty centers such as UCSF or UCD with outlying physician offices or community health centers.
   b. Live interactive (synchronous) Patient to Provider Telehealth Services connects a single provider (primary care or specialty provider) to a patient using audio-visual equipment on a real-time basis. The patient can be in a health facility, residential group home or private residence or other setting, provided the appropriate equipment is used.

Table 14 provides a listing of all eligible live interactive services with CPT codes.
Table 14
Partnership HealthPlan Telemedicine Services
Live Interactive

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit (new or established patient)</td>
<td>99201-99215</td>
</tr>
<tr>
<td>Initial hospital care or subsequent hospital care, critical care</td>
<td>99221-99233, 99291, 99292</td>
</tr>
<tr>
<td>Extended Inpatient Care</td>
<td>99356 – 99357</td>
</tr>
<tr>
<td>Consultations: Office or other outpatient, initial or follow-up patient, Inpatient, and confirmatory</td>
<td>99241-99275</td>
</tr>
<tr>
<td>Genetic Counseling</td>
<td>96040, 50265</td>
</tr>
<tr>
<td>Nutrition Counseling per PHC Guidelines (See Policy MCUP3052)</td>
<td>97802, 97803, 97804, 99539</td>
</tr>
<tr>
<td>Interactive complexity (List separately in addition to the code for primary)</td>
<td>90785</td>
</tr>
<tr>
<td>Psychiatric diagnostic evaluation</td>
<td>90791</td>
</tr>
<tr>
<td>Psychiatric diagnostic evaluation with medical services</td>
<td>90792</td>
</tr>
<tr>
<td>Psychotherapy, 30 minutes with patient/or family member</td>
<td>90832</td>
</tr>
<tr>
<td>Psychotherapy, 45 minutes with patient/or family member</td>
<td>90834</td>
</tr>
<tr>
<td>Psychotherapy, 60 minutes with patient/or family member</td>
<td>90837</td>
</tr>
<tr>
<td>Psychotherapy for crisis; first 60 minutes</td>
<td>90839</td>
</tr>
<tr>
<td>Additional 30 minutes</td>
<td>90840</td>
</tr>
<tr>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy</td>
<td>90863</td>
</tr>
<tr>
<td>Originating Site Fee</td>
<td>Q3014</td>
</tr>
<tr>
<td>Transmission Fee</td>
<td>T1014</td>
</tr>
</tbody>
</table>

Clinical Fees: Store and Forward

Store and forward (asynchronous) services, connects a member with a distant licensed provider of ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally an image or picture is taken and forwarded to the distant licensed provider to review at a later time.

Table 15 provides a listing of all eligible store and forward services with CPT codes.

Table 15
Partnership HealthPlan Telemedicine Services
Store and Forward

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit (new or established patient)</td>
<td>99201-99215</td>
</tr>
<tr>
<td>Consultations: Office or other outpatient, initial or follow-up patient, Inpatient, and confirmatory</td>
<td>99241-99243, 99231-99233</td>
</tr>
<tr>
<td>eConsult, electronic consultation</td>
<td>99444</td>
</tr>
<tr>
<td>Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists</td>
<td>92250</td>
</tr>
<tr>
<td>Originating Site Fee</td>
<td>Q3014</td>
</tr>
<tr>
<td>Transmission Fee</td>
<td>T1014</td>
</tr>
</tbody>
</table>

Additional Resources

Partnership Health Plan Telehealth Policy
http://www.partnershiphp.org/Providers/Policies/Documents/Utilization%20Management/MCUP3113.docx

Partnership Health Plan Telehealth Service Website
http://www.partnershiphp.org/Providers/Quality/Pages/Telehealth-Services.aspx
Federally Qualified Health Centers and Rural Health Clinics

Federally Qualified Health Centers (FQHC) And Rural Health Clinics (RHC) play a critical role in the provision of primary care to our rural and underserved populations. Many FQHC/RHSs are patient and/or provider sites for the delivery of telemedicine services. Telemedicine can improve patient access to specialty care and reduce travel hardships when needed services are far away. These valuable rural healthcare resources have played an important role in the development of telemedicine in California.

One of the questions most commonly asked of the California Telehealth Resource Center (CTRC) and the California Department of Health Care Services (DHCS) is about allowable billing for telemedicine by an FQHC/RHC. Many of the clinics have questions about “four walls” policies and how they are applied when telemedicine services are provided.

CTRC has worked with many rural clinic administrators and with DHCS to clearly identify the different reimbursement scenarios and the payment rules that surround each scenario. This document has been developed with input from DHCS staff. For MEDICARE patients, RHCs and FQHCs can be originating sites. They cannot provide services as a distant site.

This portion of the guide is designed to assist in maximizing allowable billing for telemedicine and to assist in determining the type of provider relationship that will best meet programmatic needs. It is written for FQHCs operating in California under the Prospective Payment System (PPS). Please note that rules for other states may differ.

There are several factors that determine how to bill for telemedicine services.

Two principles form the foundation:

- The place determined to be the provider site is the billing site and
- A provider can, under certain circumstances, enter the four walls virtually using telemedicine

The factors that determine the billing scenario are:

- Where the patient is physically located
- Characteristics of the specialty provider site
- Payment arrangement with the specialty provider
- If there is medical reason for a provider to be present with the patient

The application of these factors is described in the following eight scenarios.
### Medi-Cal Managed Care Plan (MCP)

**Scenario 1**  
**FQHC/RHC Originating Site to a Distant Site**

- Patient is physically present at the FQHC or RHC
- Specialist is a MCP contracted provider not physically present at the FQHC or RHC
- FQHC or RHC and specialist have an agreement to provide services, but the FQHC or RHC does not compensate the specialist
- No medical reason for a provider to be present with the patient at the FQHC or RHC Site

**Outcome**

- MCP contracted specialist is the Distant Site and can bill MCP
- FQHC or RHC is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face. However, the FQHC or RHC, *in most instances*, can bill an Originating Site fee and transmission fee to the MCP

---

**Diagram:**

- **FQHC or RHC Originating Site**
  - Patient
  - Bills Q3014 and T1014 to MCP

- **Distant Site**
  - Specialist
  - Bills CPT to MCP

---

**Telemedicine**
Medi-Cal Fee-For-Service

Scenario 1a  FQHC/RHC Originating Site to a Distant Site

- Patient is physically present at the FQHC or RHC
- Specialist is a Medi-Cal fee-for-service provider not physically present at the FQHC or RHC
- FQHC or RHC and specialist have an agreement to provide services, however the FQHC or RHC does not compensate the specialist
- No medical reason for a provider to be present with the patient at the FQHC or RHC Site

Outcome

- Medi-Cal specialist is the Distant Site and can bill fee-for-service rate
- FQHC or RHC is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face

*Per the Medi-Cal handbook: FQHCs, RHCs, and IHS clinic PPS sites may not bill for originating site or transmission fees.*
Multiple Managed Care Plans and Fee-For-Service Medi-Cal

Scenario 1b  FQHC/RHC Originating Site (Provider Present) to a Distant Site

- Patient is physically present at the FQHC or RHC
- Specialist is a Medi-Cal fee-for-service provider not physically present at the FQHC or RHC
- FQHC or RHC and specialist have an agreement to provide services, however the FQHC or RHC does not compensate the specialist
- Medical reason for a provider to be present with the patient at the FQHC or RHC Site

Outcome

- Medi-Cal specialist is the Distant Site and can bill fee-for-service
- FQHC/RHC is the Originating Site, provided a medically necessary service, and can bill PPS for a face-to-face visit

*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.
Multiple Managed Care Plans and Fee-For-Service Medi-Cal

**Scenario 2**  
**FQHC/RHC Originating Site to Contracted Distant Site**

- Patient is physically present at FQHC/RHC Site
- Specialist is not physically at the FQHC/RHC
- FQHC/RHC and specialist have a written agreement to provide services. FQHC/RHC compensates specialist outside of an insurance plan.
  - The agreement should be in writing and clearly state: The time period during which the agreement is in effect; the specific services it covers; any special conditions under which the services are to be provided; and the terms and mechanisms for billing and payment. (See BPHC Policy Information notice 98-23)
- FQHC or RHC has credentialed the contracted provider in house and with the health plan (if applicable)
- Specialist virtually enters FQHC site via telemedicine

**Outcome**

- FQHC/RHC becomes the Distant Site and can bill PPS for a face-to-face visit

---

*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.
Medi-Cal Fee-For-Service

**Scenario 3  FQHC/RHC Originating Site to FQHC/RHC Distant Site**

- Patient is physically present at the FQHC/RHC 1
- Specialist is physically at and receives compensation from FQHC/RHC 2
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services, however FQHC/RHC 1 cannot compensate FQHC/RHC 2
- No medical reason for a provider to be present with the patient at the FQHC/RHC 1 Site

**Outcome**

- FQHC/RHC 2 is the Distant Site and can bill PPS for a face-to-face visit
- FQHC/RHC 1 is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face visit

*Per the Medi-Cal handbook: FQHCs, RHCs, and IHS clinic PPS sites may not bill for originating site or transmission fees.*

*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.*
**Scenario 3a**  
**FQHC/RHC Originating Site (Provider Present) to FQHC/RHC Distant Site**

- Patient is physically present at the FQHC/RHC 1,
- Specialist is physically present at and receives compensation from FQHC/RHC 2
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services, but FQHC/RHC 1 cannot compensate FQHC/RHC 2
- Medical reason for a provider to be present with the patient at the FQHC/RHC 1 site

**Outcome**

- FQHC/RHC 2 specialist is the Distant Site and can bill PPS for a face-to-face visit
- FQHC/RHC 1 is the Originating Site, provided a medically necessary service, and can bill PPS for a face-to-face visit

*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.*
Medi-Cal Fee-For-Service

Scenario 4  Non FQHC/RHC Originating Site to FQHC/RHC Distant Site

- Patient is physically present at Originating Site (non FQHC/RHC)
- Specialist is physically located at and receives compensation from FQHC/RHC
- Originating Site and FQHC/RHC have an agreement to provide services, however Originating Site does not compensate FQHC/RHC
- No medical reason for a provider to be present with the patient at the Originating Site

Outcome

- FQHC/RHC is the Distant Site and can bill PPS for a face-to-face visit
- Non FQHC/RHC Clinic site is the Originating Site, did not provide a medical service, and cannot bill for a face-to-face visit. However, the clinic site can bill an Originating Site fee and transmission fee

Diagram:

- Originating Site
- FQHC/RHC Distant Site
- Patient
- Specialist

Telemedicine

Bills Q3014 and T1014

Bills PPS to Medi-Cal
Multiple Managed Care Plans and Fee-For-Service Medi-Cal

Scenario 5  FQHC/RHC to Patient Home *

- Provider is physically located at and receives compensation from FQHC/RHC
- Patient is an established patient and is not physically present at FQHC/RHC. In this example we will use the patient's home.

*Please check with your plan for eligibility

Outcome

- FQHC/RHC is the Distant Site and can bill PPS for a face-to-face visit
FQHC Specialty Care Frequently Asked Questions

*Can an FQHC contract with a specialist to provide services?*

FQHCs are allowed to contract with specialty providers to provide services to their patients. The live-interactive component of telemedicine enables the FQHC to bill for a face-to-face encounter.

PIN 98-23 3–Contracting for Health Services Health centers may have contracts or other types of agreements to secure services for health center patients that it does not provide directly. The service delivery arrangement must contribute to the desired outcomes of availability, accessibility, quality, comprehensiveness, and coordination. Arrangements for the provision of services that the grantee organization provides through a subcontractor should be in writing and clearly state: the time period during which the agreement is in effect; the specific services it covers; any special conditions under which the services are to be provided; and the terms and mechanisms for billing and payment. Other areas that should be addressed in the written agreement include but are not limited to: credentialing of contracted service providers; the extent to which the contracted services and/or providers are subject to the health center’s quality improvement and risk management guidelines and requirements; and any data reporting requirements.

*Can an FQHC add specialty care service to their practice?*

If an FQHC wishes to provide a service via telemedicine that is not currently a part of their ‘scope of practice’ they must contact their project officer for permission, or wait until their annual grant renewal to do so. HRSA PIN 2009-02 specifically addresses the topic of adding primary care services. In general, a health center must demonstrate how the new service will support the provision of the required primary care services provided by the health center. Although prior approval is still necessary, in general the addition of services listed as examples of ‘additional health services’, such as behavioral and mental health, will be considered appropriate for inclusion within the health center’s federal scope of project. The request must not require any additional 330 funding.

*Does FTCA coverage apply to contract employees?*

FTCA coverage is an ongoing concern affecting the provision of telemedicine because there are various ways that telemedicine consults could potentially void this coverage. For this reason it is recommended that the health center has wrap-around coverage. PAL 2005-01 states that “for contract providers, the contract must be between the Health Center and the individual provider. All payments for services must be from the Health Center to individual contract provider. A contract between a deemed Health Center and a provider’s corporation does not confer FTCA coverage on the provider.”

Additionally, FTCA only applies to part-time licensed or certified healthcare practitioner Contractors (who are not corporations) providing part-time services in the fields of family practice, general internal medicine, general pediatrics, or obstetrics and gynecology.
Useful References


2. California Department of Health Services, Medi-Cal Program, Internet version, Sacramento, California.
   http://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx

3. Medicare Telehealth Program
   http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/

4. Medicare Telehealth Services Fact Sheet 2018


6. *Medicare Benefit Policy* (CMS Publication 100-02), Internet publication only, Baltimore, Maryland, Centers for Medicare and Medicaid Services.

7. *Medicare Claims Processing Manual* (CMS Publication 100-04), Internet publication only, Baltimore, Maryland, Centers for Medicare and Medicaid Services.

8. *Medicare Benefit Policy Manual - Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services*


10. Anthem Blue Cross of California, *Anthem Blue Cross of California Telemedicine Program for Healthy Families and Medi-Cal Program – Telemedicine Billing Guidelines*,

11. Partnership Health Plan Telehealth
    http://www.partnershipphp.org/Providers/Quality/Pages/Telehealth-Services.aspx
tab 2 goes before page 50
Staffing a Telehealth Program

Program Guide

This Document was developed through a joint collaborative between the California Telehealth Resource Center (CTRC) and the University of Minnesota Great Plains Telehealth Resource and Assistance Center (GPTRAC/UoMN).

A Publication of:

California Telehealth Resource Center

This publication was made possible by grant number G22TH07770 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

© 2014 California Telehealth Resource Center.
Introduction

Staffing is often viewed as one of the most costly and critical components in developing and operating a successful telehealth program, but it is the staff that will ultimately determine the success of the program. It is important to take a good look at how best to develop this important program component.

Staffing consists of a variety of functions, roles and responsibilities, each role necessary for smooth and efficient delivery of services and operation of the telehealth program. As part of the development process, each telehealth program will need to determine how each function will be addressed – with existing staff? With new staff? Within which department? Developing telehealth program staffing will be influenced by factors including the type of service site, anticipated services and service levels, size of the site, anticipated volume, and available funding.

While the roles and functions necessary for telehealth operations have been well defined and described, each program will need to adapt the general knowledge for their unique needs and resources. Additionally, organizations have staff with different skills, strengths and interests. Making the most of existing staff strengths and structure will be an important consideration when developing your staffing plan.

In the CTRC Program Development process, staffing considerations, analysis and decisions occur during Step Two, Define A Program Model and Step Four, Develop The Detailed Program Description and Plan. The staffing plan that is needed for any given program should be developed as the program’s design is established. The size, scope and type of program will impact staffing requirements and should be taken into account before staffing decisions are finalized.

This guide provides information and suggestions for staffing a successful telehealth program. It describes the functions, roles and responsibilities most often associated with telehealth programs. This guide contains a template to assist programs in identifying and assigning critical functions, roles and responsibilities and contains sample duty statements for some commonly used positions. This guide can be used to identify any gaps in the staffing plan for your new program, as well as to provide a few ideas to help strengthen an existing, growing telehealth program.

The information presented is generally adaptable to all types of telehealth programs.

CTRC has three on line training videos that support this guide: Patient Site Roles and Responsibilities, Provider Site Roles and Responsibilities and What Every Telemedicine Presenter Needs To Know. Other program assistance materials can be found at CTRC website - www.caltrc.org.
Eight Key Functions and Corresponding Staff Roles

Eight functions have been identified as essential when establishing and then sustaining a telehealth program. Covering all these functions and roles is vital to success. It is important to understand these functions, how they differ and how they work together. It is valuable to consider each of the functions before deciding on staff roles, responsibilities and assignments. The eight functions are:

1. Project Management
2. Program Management
3. Program Operation and Site Coordination
4. Clinical Direction and Oversight
5. Clinical Referrals
6. Clinical Service Provision
7. Patient Presentation
8. Technical Support

After considering the necessary functions for a telehealth program, each function needs to have a more defined set of roles and responsibilities. These can then be assigned to specific staff, either new or existing. In many programs one person may be responsible for or perform more than one function or role. The actual number of staff will need to be identified as your program scope, service type and service levels are identified.

1. Project Management
   Function
   Program Development / Project Management – The Project Management function is part of the initial development or subsequent expansion of a telehealth program. The Project Management function coordinates all the efforts necessary to research, plan, build, implement and manage the program. Project management involves using specific tools to define the project, identify and involve stakeholders, track and manage the specific steps (including timelines), resources, and goals necessary for the project to be successful. Proper project planning and management (including the use of appropriate tools and processes) helps to assure that clinical, operational and technical expectations and requirements are identified, met, or exceeded, therefore encouraging the successful outcome of the project.

   Projects by their nature are limited in scope and time and the Project Management function concludes at the end of the development process. The project management function is different than the on-going program management function discussed below. Best Practice: Successful program development has an assigned project manager.

   Make sure to identify the differences between the “project” of the initial implementation or expansion of a telehealth project, and the on-going operations of the institutionalized and sustained telehealth program. It is common in smaller programs to have the project management function combined with the program management function. The same individual developing the program is then responsible for managing ongoing operation.

   The Program Development Function should be assigned before any of the work begins on the development of the telehealth program.
Role
Program Developer / Project Manager – The Project Manager role assumes responsibility for overall development of the telehealth program, including research, creation of development products such as needs assessments and program descriptions, create and execute project work plans and revise as appropriate to meet changing needs and requirements, identify resources needed and assign individual responsibilities, manage day-to-day operational aspects of specific projects and the corresponding scope. This position is responsible for all project accounting aspects including the tracking and reporting of team hours and expenses and managing of the project budget.

This position is responsible for identifying the key stakeholders and incorporating them in the planning and implementati on processes. At this point, many of the positions that are indicated below may not have been identified, but there should be representation from the various stakeholders they represent (administration, nursing, IT, rural/specialty medical staff, clinic staff, etc.)

If your organization is fortunate to have a full time project manager on staff, this person will transition the project, at its completion, to the program manager. However, in small clinics it is often the case that the program manager also functions as the project manager. The description of the role simply shifts from that of getting the project up and running to that of the long-term operational aspects.

It can be very helpful to obtain technical assistance from experienced telehealth program developers during the initial development of a telehealth program. They bring expertise, experience and often tools to support the development process.

2. Program Management
Function
Program Management – The on-going operational aspects of the telehealth program fall under this function. This includes general management activities such as increasing organizational awareness, on-going staffing, human resources management, policies and procedures, coordinating with other patient care departments, educating patient-care departments, providing the guidance and training necessary to meet the needs of patients being served, coordinating the licensing/credentialing needs of practitioners, encouraging and coordinating service development and expansion, tracking customer satisfaction (remote sites, patients, providers, etc), data collection (service utilization, service access, etc.) and performance monitoring and reporting.

Role
Program Manager – The Program Manager role is responsible for managing all the operational aspects of the telehealth program including but not limited to needs assessment, policy and procedures, workflow and staffing. This position is usually responsible for planning, designing, controlling, directing, coordinating, and evaluating the performance and status of all resources (personnel, hardware, software, bandwidth, etc.) of the telehealth department.

This position works in cooperation with all of the positions indicated below to provide guidance and assistance. Additionally, this is the position that interacts regularly with the organizational leadership to keep them educated and updated on telehealth activities.
3. Program Operation and Site Coordination

Function

**Program Operation / Site Coordination** – This function includes activities related to operations and providing assistance as needed to the practitioners at both the patient and practitioner’s locations. The success of the remote patient site is critical to the overall success of the entire telehealth program. A significant amount of coordination and commitment is required at the patient site. It is important to have a specific point of contact to provide assistance to other local staff and to serve as a champion for the telehealth program within the facility.

Roles

**Telehealth Operations Manager or Telehealth Coordinator** – The Telehealth Coordinator is perhaps the most used role for telehealth programs. In smaller organizations the Telehealth Coordinator often functions as the Program Manager, the Service Coordinator and the Clinical Presenter. This position is usually responsible for developing and enhancing clinical telehealth services and applications. This includes, but is not limited to, consulting with partner sites to determine and assess clinical needs and requirements; establishing and documenting proper procedures and policies regarding telehealth consultations, training personnel involved, assuring scheduling and other processes operate effectively and integrate with overall organizational processes; and communicating regularly with the medical director and program manager. These positions are used at both patient and provider sites.

As clinical services are identified and developed, this position will likely have some interaction with the organization’s clinic management and/or business development leader(s), and with the billing, quality, and credentialing departments as well.

While the ultimate goal is to incorporate telehealth services as a component and tool of a clinical practice, thereby allowing clinic staff to be responsible for conducting their own telehealth events, as a program is initiated it is likely that this position will be actively involved in the delivery of patients services. Assistance may be needed with scheduling medical specialists for telehealth consultations, coordinating with remote sites and verifying the presence of the patients to be seen, ensuring that the necessary clinical records and information is available for the Patient and the clinician, confirming licensing and credentialing, and verifying that the equipment is functional prior to the beginning of consultations. The telehealth coordinator may function as a clinical presenter during patient care visits and may also complete any necessary paperwork including billing forms and communications with referring practitioners.

Because of the functions of this position and the knowledge and skills required in the area of patient care and issues surrounding providing that care, many programs fill this role with a Registered Nurse (RN).

**Patient Site Coordinator** – Some programs differentiate between the Provider Site Coordinator (sometimes called a Hub site) and a Patient Site Coordinator role. Patient site coordinator serves as the prime contact person at the remote (Patient) service location. This position is often required to handle multiple functions serving as an advocate for telehealth within the facility, coordinating the actual use of the equipment by various interested parties (education, patient services, administration), assuring proper policies and procedures are in place, assisting with data collection and evaluation activities, and coordinating with other staff to assure Medical Staff requirements are met.

Many rural sites do not have the luxury of multiple individuals to serve in the many roles indicated in this listing, so often one person has to be versed in a variety of responsibilities.
4. Clinical Direction and Oversight

Function

Clinical Direction and Oversight – This function assures that there is adequate and appropriate clinical oversight to the services being provided by telehealth. Making sure that telehealth services are provided appropriately, are meeting the identified needs and are accessible, all without undue burden to the patients and staff being served is important. This function occurs at both the patient site and the provider site.

Role

Clinical Director – The Clinical Director serves as the liaison between the telehealth program and the rest of the organization’s clinical staff for the purposes of program awareness, provider recruitment, service development, provider training, and general communication. This position often serves as the program champion by providing encouragement, direction, and medical/clinical oversight of the telehealth program. The Clinical Director works closely with the Program Manager, Operations Manager and Telehealth Coordinator. A Clinical Director should be assigned at both the patient and provider sites.

5. Clinical Referrals

Function

Clinical Referrals – The practitioner at the patient site is often the gate-keeper for patients as they access telehealth services. Often, it is the practitioner who will identify a patient with a need to receive specialty care utilizing telehealth services. Already-established relationships with specialty providers is often what determines the referral.

Role

Patient Site Referring Clinician – In medical settings, this is usually performed by the patient site primary care provider. The referring clinician at the patient site determines when a patient needs a service not available on site and will make the referral to a telehealth practitioner. The referring clinician identifies patients that may be suitable for telehealth services and often is the initiator of the consult for specialty services.

This position relies on the combined skills of the remote site coordinator and the patient presenter to facilitate the telehealth interaction between patient and telehealth specialty practitioner. Additionally, there may also be interaction with the Telehealth Coordinator and the Medical Director to ensure that services are available to meet the community’s needs and to address any quality improvement issues.
6. Clinical Service Provision

Function

Clinical Service Provision – The practitioner at the specialty or other service site provides the service being requested by the referring practitioner. The clinician may also directly request telehealth services for a patient as part of their follow-up care.

Role

Telehealth Provider / Clinician / Practitioner – The practitioner is located remotely from the patient and is often a clinical specialist of some kind. This position is responsible for leading and conducting the actual patient interaction as well as directing the actions of those assisting the patient. In some cases, the practitioner is actually directing the care of the patient remotely. In other cases, the practitioner is serving only in a consultative role to the patient’s primary provider.

This position usually relies heavily on the services of the patient presenter when seeing a patient. In many patient events, information from an electronic stethoscope, various video scopes, or other peripheral devices may be needed, as well as information from the patient’s electronic medical record.

7. Patient Presentation

Function

Patient Presentation – Since the idea of telehealth is to access services not available within the facility, it is expected that the practitioner providing the service is not physically located with the patient. In most cases, the remote clinician will require some level of clinical or technological assistance with the patient interaction or examination. This includes serving as an extension of the clinician by assisting the patient, operating the telehealth equipment, utilizing peripherals, as needed, and ensuring that a patient’s needs and the standards of care are being met.

Role

Patient Presenter – The patient presenter works with the remote telehealth clinician to present the patient. This presenter explains the visit to the patient and introduces the patient to the practitioner. The presenter is tasked with obtaining informed consent based upon the facility’s policy, ensuring that the patient’s charts are available and accessible, and anticipating and preparing the patient for the event. This person serves as the extended hands, eyes and ears of the practitioner at the patient-end of the connection during live interactive consults. This requires the ability to operate the telehealth equipment and usually requires the understanding and use of various scopes and other peripheral devices. This also involves patient discharge, patient education, and coordinating of additional care. When store and forward equipment is used, the presenter captures the digital images as well as the necessary clinical information to forward to the remote practitioner.

The role of Patient Presenter can be filled by many individuals. Many organizations have determined that having only one or two individuals trained to serve as the patient presenter is not very efficient. In order to incorporate telehealth as a core service, some organizations have determined that all nursing and/or medical staff should be able to serve in this capability, to be able to present patients to the telehealth practitioner as the need arises.
8. Technical Support

Function

Technical Support – Making sure that the equipment and network is set-up to encourage the smallest amount of “down time” and the highest level of “usability” is a significant part of the technical support function. While the technology has certainly become much easier to use over the past many years, there is still a need to be able to provide on-going technical support to the users of the telehealth services. Nothing is infallible, and while the frequency of equipment failure or glitches are small, there is a likelihood that equipment challenges will occur when you least want them.

Role

Technical Specialist/Network Analyst – The technician is responsible for the day-to-day functioning of the telehealth equipment and related network issues and peripherals (i.e. bridge, stethoscopes, routers, etc.). This includes the appropriate testing, operations and maintenance of the equipment, supporting proper and appropriate usage by the users, establishing/maintaining appropriate network infrastructure, and adhering to appropriate equipment-related organizational policies and procedures. This person should be available when there are technical difficulties with live telehealth sessions.

This position works in regular cooperation with Telehealth Coordinator in order to maintain a usable network to best meet the needs of the patients served. In larger organizations, the technical and network roles are often served by different people.

Some Additional Functions

There may be, depending on the services provided, additional functions that should be addressed. Some of these include:

Function

Distance Education Coordination – Some organizations have established a very specific focus on educational offerings. As a result, the coordination of these events is important for proper delivery and improved educational value. Making sure that both presenters and participants have a rewarding experience is the primary goal.

Function

Event Scheduling – If the volume of your services climbs to a level of use that can justify it, having someone tasked specifically with scheduling may be helpful. Some programs establish different scheduling processes between administrative and education events and clinical events and have chosen to keep these two focuses separate in the scheduling process. Some programs have not necessitated the need for the separation and both focus areas are scheduled through the same process.

Function

Administrative Assistance/Accounting – In some larger health system-based programs and some university-based programs, the involvement of and sometimes volume of grants dictates the need for additional administrative and accounting assistance.
Function
Quality and Research – In some organizations, the importance of evaluation and data comparison is at such a level that it is established as a separate function.

Function
Patient Monitoring – In the case of home health programs, establishing and maintaining a relationship with the patient being monitored is a key function. Observing and communicating with the patients involved in the program is the core to home-based telehealth services.

Identify Other Key Stakeholders
Additional organizational members on both ends of the service need to be involved in and aware of the telehealth implementation as well as be kept apprised of the continuing activities and services of the telehealth program. This on-going communication will encourage long-term support of your telehealth program and lead to its ultimate sustainability. The first step to figuring out how to incorporate telehealth into the organizational infrastructure is through regular communications and awareness building.

Chief Executive Officer/CFO/CIO/Lead Administrative Team – Organizational leaders need to be informed and educated about the benefits and operation of telehealth. As organizational priorities are identified, it is important for them to understand exactly how telehealth services can make an impact and assist the organization in accomplishing annual and long-term goals. If they understand the value that telehealth can bring to the organization, they are much more likely to support it, philosophically and budgetarily, in the future.

Chief of Medical Staff – In many organizations this is a rotating position, but it is important to establish communication early and often with whomever is serving in this role (and then again when the next person takes over). Gaining this person’s support, or at least building their awareness, is an important block in the foundation of the program. If the organization has a full-time position for this role, it would be highly beneficial to engage this person as a telehealth champion. As new providers/physicians are recruited to serve within the organization, that person has the opportunity to encourage or require the use of telehealth services.

Director of Nursing/Chief Nursing Officer – This person directs the overall activities of the organization’s nursing staff. This person is pivotal to telehealth program success. Gaining their support and buy-in from the beginning of the project planning phase is important.

Business Office/Billing Staff – Communicating with someone who understands your organization’s billing process and working with them to make a plan for incorporating telehealth services into the established structure will be important.

Outreach/Service Development Staff – As you consider and evaluate services to provide and/or receive, make sure to stay in regular contact with other staff also involved in outreach activities. It is important to collaborate with others striving to develop and grow services so as to not present conflicting messages and to create partnerships that support the efforts of the outreach staff.

Training/Education Staff – Often one of the services offered by a telehealth program is education. It is important to involve the education staff in the initial planning and stay in regular communications with them along the way. Staying informed about current and future educational needs as well as current in-house offerings will help to develop a plan for future development efforts. Additionally, they can help identify appropriate training methods for training staff of the telehealth program. They may also have
regularly scheduled education sessions where awareness-building for telehealth could be incorporated. It is also necessary to appropriately train individuals to be successful clinical presenters.

**IT Staff** – Keeping in close communication and establishing a partnership with this group will be a critical key to the overall, and long-term success of the telehealth program. Providing telehealth services will have an impact on the facility’s current network infrastructure. Establishing regular communications with this group, including making plans to manage the initial impact, as well as the on-going anticipated usage and potential service growth, will strengthen their understanding of, commitment to and ultimately their support of telehealth services within the organization. This group often does not get to see the impact they have on direct patient care, so make sure to share your success stories with them.

It is important to keep in mind that these positions need to be addressed at both the patient site and the provider site. It is important that communications be active to and from the leadership at both the remote facility and the provider location. Garnering support for the telehealth efforts is important at both ends of the telehealth services link. A weakness on either end can lead to failure.

**Organizational Placement of Telehealth**

Many developing programs ask about the ideal placement within the structure of your organization. In May of 2007, the University of Kentucky, Kentucky Telecare telehealth program conducted a survey of telemedicine programs across the country to obtain information on this subject. The results indicate that there is not one best answer, but each organization had to try to identify the best fit for their program. The survey results indicate:

- 44% administration-level department
- 15% Information Technology
- 11% Clinical Enterprise
- 9% Education
- 21% Other

It is likely that as the telehealth program is initiated within a facility or organization the staffing will be organizationally located across several already established departments, with one or two individuals serving as the leader(s) responsible for the success of the overall program.

There may be logic for dividing out components of your program which will always remain under another department’s control. Some examples of this might be: credentialing and privileging – it might be best to simply coordinate with the current credentialing department instead of taking on those complicated processes specifically for the telehealth-related services; or technology – there may be some value in having the information technology department be in charge of the actual telehealth hardware as they may already have processes and understanding for hardware installation requirements, upgrades, network issues, tracking and more.

In situations where responsibilities are delineated out to other departments, it is highly recommended that a specific individual (or individuals) be identified as the department lead for telehealth. This helps to develop a level of expertise in telehealth-specific issues and needs and identifies a “go to” person for questions and difficulties that might arise.
Developing A Staffing Plan

Now that you have an understanding of the functions and commonly used roles, it is time to develop a staffing plan for your organization.

The number of staff recommended for your program will depend on the size of your organization as well as the anticipated size and volume of your initial program. While often one person can be involved in multiple program roles, especially at the beginning, organizations are strongly encouraged to be careful not to overload one person with too many various components. This not only can weigh very heavily on one person, it can also have a detrimental impact on your program. By spreading the responsibilities across multiple individuals, a program builds multiple levels of buy-in and commitment to the success of the program. As the number of clients being served through the program grows, the staffing will also need to grow to meet the patient need. At some point in the program development, it may be necessary to have a stand-alone telehealth department and staff. However, as the program begins, the responsibilities of telehealth may be best served by existing staff.

While program structure may vary significantly, the core functions and responsibilities of those same programs are often very similar.

A matrix similar to the one below can be used to identify who is doing what at both ends of the service and to also identify responsibilities that may not be currently covered. A more detailed Sample Staffing Matrix and a corresponding template is found in the Appendix of this Guide. This matrix can be used to identify large functional group responsibility but can also be used to add specific activities and tasks as they are identified and assigned.

Sample Staffing Matrix

<table>
<thead>
<tr>
<th>Functional Area</th>
<th>Project Manager</th>
<th>Program Manager</th>
<th>Program Coordinator</th>
<th>Patient Presenter</th>
<th>Referring Clinician</th>
<th>IT Staff</th>
<th>Clinical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Development /Project Management</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Management</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Operations / Site Coordination</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Direction and Oversight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Service Provision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Patient Presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Technical Support</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Identifying Necessary Skills and Knowledge
Telehealth will require that staff learn some new skills and expand their knowledge base to incorporate the technical and clinical aspects of telehealth. For some staff, operation of the equipment and medical peripherals will be a necessary competency. Learning to work with clinicians and patients using videoconference technology will be critical.

The Skills and Knowledge Area Matrix found in the Template Section of this Guide provides a listing of skills that each position should have and its related importance for the indicated position. This information will help you identify what training will be required and may assist in determining which staff may be right for certain functions and roles.

Assigning Responsible Staff
The following is a list of high level functions that should be addressed, in some manner, as you begin to establish, or expand, your telehealth program. These functions may be filled by individuals identified as telehealth staff or by those in other departments providing directed assistance.

<table>
<thead>
<tr>
<th>Function</th>
<th>Position Responsible for Function</th>
<th>Staff Member Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operations/Coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Direction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Referrals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Service Provision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Presentation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Program Challenges Related To Staffing
Staffing challenges can impact developing and maintaining a successful, progressive telehealth program. Program Development efforts and ongoing management will need to consider strategies to address these areas. Some of those challenges center on staffing issues.

1. Finding The Right People
Implementing telehealth takes flexibility and a commitment to change. Often the first challenge is finding interested and enthusiastic individuals who will be committed to the program and making things work. It is important to have key staff that have a flexible work style, a customer-service/patient-centered focus, and an interest in figuring out how to make things work. Knowing that bringing something new or different into an organization can be complicated, the people working on the project, and hopefully ultimately the long-standing institutionalized program, must understand the difficulties before them and still be excited about the opportunities telehealth can bring to the organization in spite of the challenges. Good communication skills are a must and a willingness to learn about new technologies are a must.
2. Staff Retention
Many programs report that staff turnover is an ongoing challenge, particularly in rural health clinics. As the program is initiated, having an understanding that this will happen, and being prepared for it when it does happen, will help sustain the program in the long run. One of the important things to consider when developing the telehealth program is how much of the success of the program is tied to one person... and what would happen if that one person was no longer there. Making sure that appropriate policies and procedures are identified and in place, as well as having detailed job descriptions, will be helpful as transitions occur. Additionally, it is important to make sure that departmental staff are cross-trained in all roles to reduce the challenge of staff transitions. Some of the key staff that could see regular change include: administrators, program managers, clinical presenters, practitioners/physicians at both the patient and specialist locations, remote site telehealth coordinators and technical staff. Assuring that the organization supports and understands the program will significantly lessen the impact of staff turnover issues when they occur.

3. Obtaining Adequate and Appropriate Training At The Right Time
Training of staff is an ongoing need. As vacancies occur and telehealth program staff are hired, training will be necessary in both clinical and technical aspects of the program. In addition, keeping up skills is necessary when use of the telehealth equipment is infrequent. Both of these situations require the availability of training. Newly developing programs will need to identify strategies for training. This guide contains a detailed matrix on skill sets required by different staff involved with telehealth. CTRC has a series of training videos that can be used for training. The National School for Applied Telehealth, the University of Minnesota, the University of California and others have on-line and in person training programs available.

4. Budgeting for Required Staff
Identifying ongoing budget dollars to support the program in the long run can be a significant challenge. Often initial start-up funding can be obtained from local, state, federal, or foundation grant dollars to support the initial pilot project. The ongoing dollars needed to support the staff necessary for maintaining strong, sustainable programs is often more difficult to identify. This is where your ongoing evaluation and data tracking activities will show their value. The ability to demonstrate dollars-saved, revenue gained, increased patient volume, a reduction in provider turnover, increased patient satisfaction and more, will go a long way to help in securing those annual operating dollars that are needed to sustain the program, including the positions identified above.

Conclusions and Best Practices
As determinations are being made regarding the appropriate staffing structure and model for your organization, it is important to remember that there are no carbon copies. Each organization has a unique history, culture, need, and structure. Additionally, each team member brings unique skills and interests to the program. Understanding your organization, your team members, and then making sure that all of the necessary program needs and functions are being met, will certainly help you develop a staffing structure that will best meet the needs of your telehealth program.

Ultimately, it is important to keep the main goal of telehealth in mind during all planning and discussion sessions: how the program can best meet the needs of the patients served as well as the clinicians serving them. Keeping the patient in mind, among all of the other factors being considered as the program is being developed (strategy, budget, equipment, etc.), will help to guide your decisions.
Best Practices related to staffing include:

- Assure that the function of project management has been assigned to a staff member or a contractor.
- Contractors with telemedicine development experience can be used to assist a newly development program with project management and with program development expertise.
- Find training programs that support different staff functions.
- Find ways to regularly assess staff skill levels and to provide immediate training to newly assigned staff.
- Have more than one staff member skilled and assigned to patient presentation.

Tools & Templates

Template: Staff Positions Responsible for Functional Areas
Template: Staff Assignments by Functional Area
Skill and Knowledge Area Matrix (CTRC Document)
Sample Duty Statements: Program Manager, Telehealth Program Coordinator, and Clinical Presenter
Sample Staffing Matrix

<table>
<thead>
<tr>
<th>Functional Area</th>
<th>Identified Staff Role / Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Development / Project Management</td>
<td>X</td>
</tr>
<tr>
<td>Program Management</td>
<td>X</td>
</tr>
<tr>
<td>Program Operations / Site Coordination</td>
<td>X</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Direction and Oversight</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Referrals</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Service Provision</td>
<td>X</td>
</tr>
<tr>
<td>Patient Presentation</td>
<td>X</td>
</tr>
<tr>
<td>Technical Support</td>
<td>X</td>
</tr>
</tbody>
</table>

Template
Staff Assignments by Functional Area

<table>
<thead>
<tr>
<th>Function</th>
<th>Position Responsible for Function</th>
<th>Staff Member Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operations/Coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Direction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Referrals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Service Provision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Presentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical Support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Skills and Knowledge Area Matrix

Listed below are some important skills and knowledge areas for telehealth program staff. Six commonly used roles are identified and roles may be assigned to one staff person. For a brief definition of each role, please refer to the end of this document.

THIS MATRIX IS PROVIDED AS A GUIDE. EVERY PROGRAM WILL NEED TO DETERMINE THE SPECIFICATIONS FOR ROLES WITHIN THEIR OWN PROGRAM.

<table>
<thead>
<tr>
<th>Skill or Knowledge Area</th>
<th>Program Manager</th>
<th>Telemedicine Site Coordinator</th>
<th>Patient Presenter</th>
<th>Referring Clinician</th>
<th>Remote Practitioner</th>
<th>Technical Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand the benefits of telehealth program</td>
<td>++++</td>
<td>+++++</td>
<td>++++</td>
<td>++++</td>
<td>++++</td>
<td>+++</td>
</tr>
<tr>
<td>Preparing a needs/market Analysis</td>
<td>++++</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Business Model Development and Sustainability</td>
<td>++++</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Organizational Readiness</td>
<td>++++</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Strategic Planning and Telehealth Applications</td>
<td>++++</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Project Management for Telehealth</td>
<td>++++</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Managing Organizational Change</td>
<td>++++</td>
<td>+++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Skill or Knowledge Area</td>
<td>Impact of Telehealth on Organizational Operations</td>
<td>Legal Considerations</td>
<td>Privacy and Security</td>
<td>Reimbursement</td>
<td>Practices of Successful Programs</td>
<td>Evaluation of Program Operation and Effectiveness</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>----------------------</td>
<td>----------------------</td>
<td>---------------</td>
<td>----------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Technical Specialist</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Remote Practitioner</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>Referring Clinician</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Patient Presenter</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Telemmedicine Site Coordinator</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Program Manager</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
</tr>
</tbody>
</table>

**Staffing a Telehealth Program**
<table>
<thead>
<tr>
<th>Skill or Knowledge Area</th>
<th>Program Manager</th>
<th>Telemedicine Site Coordinator</th>
<th>Patient Presenter</th>
<th>Referring Clinician</th>
<th>Remote Practitioner</th>
<th>Technical Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video Standards and Specifications</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Telecommunications Installation</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Telecommunications Operation</td>
<td>+</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Telecommunications Maintenance</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Troubleshoot Telecommunications Connections</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Service level Agreements</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Telemedicine Specific Clinic Operation Procedures</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Scheduling Follow-up</td>
<td>++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Telemedicine Specific Referral Procedures</td>
<td>++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Managing Medical Record</td>
<td>++</td>
<td>+++</td>
<td>+++</td>
<td>++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>++</td>
<td>+++</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Clinical Protocols</td>
<td>++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>Role of the Patient Presenter and How to Work with Presenters</td>
<td>+</td>
<td>+++</td>
<td>+++</td>
<td>++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>Performing Telemedicine Consultations</td>
<td>++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>Inform Patients About Telemedicine Process</td>
<td>++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Using the Telemedicine Equipment</td>
<td>+</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>Data Collection</td>
<td>++</td>
<td>+++</td>
<td>++</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
</tbody>
</table>
Definitions for Commonly Identified Telemedicine Staff Members

Program Manager: The program manager provides overall management and oversight of program activities. The program manager is the leader of the telemedicine team. He or she represents the group, advocates on its behalf to the organization and manages the staff. The manager reports on the function and progress of the service, directs any process and improvement activities, negotiates budgetary issues, recruits and hires staff, sets priorities in consultation with the team, and supervises its functioning.

Telemedicine Site Coordinator: The telemedicine coordinator manages the day-to-day clinic operations. He or she develops operational protocols, schedules medical specialists for telemedicine consultations, schedules and verifies the presence of the patients to be seen, ensures that the necessary clinical records information is available for the patient, and verifies that the equipment is functional prior to the beginning of consultations.

Patient Presenter: The patient presenter works with the remote practitioner to present the patient. This person introduces the patient to the practitioner and explains the visit to the patient. The presenter is usually tasked with providing and documenting the written and verbal patient consents (required in California) and ensuring that the patient’s charts are available. This person is the extended “eyes and ears” of the practitioner at the other end of the connection during live interactive consults. When store and forward equipment is used, the presenter captures the digital images as well as the necessary clinical information to forward to the remote practitioner.

Referring Clinician: The referring clinician determines when a patient needs to be seen by a remote practitioner. The clinician screens patients that may be suitable for telemedicine services and initiates the consult for specialty service.

Remote Practitioner: The remote or consulting practitioner is responsible for conducting the actual telemedicine visit.

Technical Specialist: The technical specialist possesses the technical skills to set up and maintain all telemedicine equipment. This person is tasked with ensuring that telecommunications and networking issues are addressed and resolved and should be available when there are technical difficulties with live examination sessions.
Sample Duties Statement

Program Manager

Manage all aspects of the telehealth department including but not limited to staff, programming and system implementation, hardware/software requirements, system/user priorities, and workflow. Responsible for planning, designing, controlling, directing, coordinating, and evaluating the performance and status of all resources (personnel, hardware, software, bandwidth, etc.) of the telehealth department.

Duties and Responsibilities

• Reviews and establishes departmental policies, procedures and plans.

• Develops and directs telehealth priorities for the organization in concert with and at the direction of leadership.

• Responsible for the collection, analysis, maintenance and reporting of statistical data to identify, diagnose, and correct problems/factors affecting performance, to track utilization, and other needs.

• Designs methods and procedures for efficiency, productivity, and control of operations and coordinates day-to-day operations.

• Provides planning, consultation and advisory services on telehealth development and issues to determine feasibility and applicability to organizational needs.

• Maintains effective communication and awareness by consulting with physicians, physician offices, affiliates, and department directors and/or representatives to discuss telehealth needs and directions.

• Prepare the departmental annual budget and with on-going review and action assure that budgeted objectives are achieved and that cost and expense objectives are met.

• Represent the organization on appropriate telehealth-related activity and/or planning groups on an organizational, regional and national level.

• Supervise the administration of telehealth-related grant funds.

• Serve on any and all grant fund related committees (federal, regional, state, and local).

• Be knowledgeable on public policy issues and the possible impact to telehealth services

• Actively advocate and build the awareness for telehealth at all governmental levels.

• Balances limited resources with conflicting priorities.

• Oversees the coordination efforts with the Education Departments on the availability of programs to be broadcast via video conferencing.

• Approves the purchase, license, or other acquisition of telehealth-related systems for the organization in order to encourage cohesion and compatibility.
Sample Duties Statement

Telemedicine Coordinator

Responsible for developing and enhancing clinical telehealth applications. This includes, but is not limited to, consulting with rural partner sites to determine and to assess their clinical needs and requirements; establishing and documenting proper procedures and policies regarding telehealth consultations; and training personnel involved.

Duties and Responsibilities

• Serve as primary liaison with primary care physicians and their clinical staff.

• Assist clinicians with the telehealth applications.

• Promote the awareness of telehealth usage/applications among medical staff, the nursing community and allied health professionals within the organization and the region.

• Develop/manage/coordinate clinical efforts within the organization and at partner sites.

• Work with the program manager and other clinicians to conceptualize and develop clinical applications.

• Assist the clinicians during consultations when necessary.

• Train rural partner site nurses, physicians, and care extenders to perform clinics.

• Become familiar with issues and concerns that may arise regarding patient billing.

• Be involved with educational program development and assist presenters as necessary.

• Participate in and develop appropriate documentation of usage, satisfaction, and other relevant statistical and quality data and information.

• Travel to partner sites to promote clinical involvement of rural clinicians.

• Work in cooperation with all telehealth staff to develop appropriate guidelines and policies/procedures.
Sample Duties Statement

Clinical Presenter

Responsible for scheduling patients, preparing charts, presenting patients to the remote physician, completing required patient charting and collecting encounter data.

Duties and Responsibilities

- The clinical presenter is present during every telemedicine visit to properly inform and introduce all parties involved prior to the start of each visit.
- Excellent verbal and written communication skills to convey information clearly to the remote physician.
- Maintains patient confidentiality.
- Presents each patient visit and locates and presents medical information from the medical record as directed by the attending physician.
- Assures that the required clinical follow up, diagnostic testing and medication processing are completed.
- Responsible for operating and basic troubleshooting of telemedicine equipment.
- Regularly communicates with the Telemedicine Coordinator and provides feedback on institutional procedures that may exist that impact the operation of telemedicine.
Sample Telemedicine Job Descriptions
The Telemedicine clinic staff, from the Medical Director to the Site Coordinator, have a unique set of duties and responsibilities, in addition to their traditional roles within their organization. These responsibilities require an elevated skill set that is reflected in the sample job duties and job descriptions in the following pages.

In this document, you will find reference to the following roles on the telemedicine team:

1. Medical Director
2. Site Coordinator for the Patient Site
3. Site Coordinator for the Specialty Site
4. Instructor
5. Clinic Manager
6. Technical Support
TELEMEDICINE MEDICAL DIRECTOR

Purpose:

To provide oversight of all clinical activities, including clinical quality improvement, and serve as a liaison between referring and consulting physicians.

Duties:

- Oversee the implementation plan of sites, specialties, and other telemedicine clinical and educational services.

- Assist in coordinating clinical activities with participating specialists, evaluates scopes and other peripheral devices for clinical appropriateness, provides guidance on the potential uses of telemedicine, and outlines the opportunities and limitations of the technology.

- Responsible for evaluation and research in the areas of equipment utilization, cost-benefit analysis, and clinical efficacy and outcomes.

- Participate in policy development at the local, state, and federal level.

- Incorporate telemedicine as a strategy in the area of rural health and affiliation development.

- Act as liaison to the medical community, providing education regarding the appropriate applications and opportunities provided by telemedicine.
TELEMEDICINE SITE COORDINATOR PATIENT SITE

General:

Serve as point-of-contact for telemedicine activities at health care facility. Responsible for operation of telemedicine program at individual site. Schedule appointments, set up and test equipment, collect evaluation data, support physicians and other providers during consultation, promote program in local community.

PROGRAM COORDINATION

- Serve as the primary contact for scheduling of the telemedicine and videoconferencing equipment.
- Organize on-site training for users of the telemedicine, videoconferencing, and remote monitoring systems.
- Responsible for working with appropriate site staff to bill for telemedicine services.
- Organize demonstrations of the system for visitors.
- Provide or arrange for basic technical support and perform or provide for general system maintenance.
- Coordinate with the technical support team to ensure that problems and system development needs are addressed.
- Assist in data collection and report generation.

TELEMEDICINE CLINIC ADMINISTRATION

- Triage incoming telephone calls and appropriately handle each call by obtaining adequate information to make a proper telemedicine referral, and schedule the teleconsultation.
- Prepare consult room and equipment prior to scheduled consults. Make sure successful video connection has been made and stand by during consult to provide technical assistance when necessary.
- Create and distribute telemedicine clinic schedules, promotional material, documents, consent forms, satisfaction surveys, and various items of information to on-site medical staff and patients.

PATIENT CARE COORDINATION

- Answer patient/family and referring physician questions appropriately and within the realm of knowledge/expertise, and expediently and appropriately relay the information to the proper. Provide follow-through to ensure that all issues/questions are resolved.
• Act as a liaison between referring physicians, patients, staff and consultants, clinic staff, patient accounts, funding sources, and other departments or services as needed.

• Assist the consultant physician with scheduling the patient for clinic appointments, procedures or with a direct admission, if the patient requires hospitalization, as outlined in health facility protocols.

EDUCATION AND OUTREACH

• Facilitate the operation of continuing educational programming utilizing the telemedicine equipment.

• Responsible for scheduling telemedicine facilities and for the technical preparation for educational sessions.

SKILLS, KNOWLEDGE AND ABILITIES

• Good verbal and written communication skills.

• Experience working in a clinical setting with technicians, nurses and physicians.

• General knowledge of patient scheduling systems and billing system.

• Computer skills and an ability to learn and understand the general technical requirements for the telemedicine system. With training, ability to provide basic technical support and to triage more difficult problems to appropriate staff.

• Proficiently operate a PC, and experience with/or ability to learn word processing, spreadsheet, database, e-mail and internet programs (Excel, Word, Access, etc.).

• Organizational skills to prioritize workload and meet deadlines, develop and carry-out project assignments in an efficient and timely manner and to provide accurate and succinct documentation of activities.

• Demonstrated ability to communicate effectively with physicians and clinical staff. Ability to positively represent telemedicine to external organizations and participants.

• Ability to exercise tact, courtesy and diplomacy when dealing with individuals at any level.

• Ability to maintain confidentiality, exercise discretion, use independent and mature judgment, work independently without supervision and commitment to excellence.
General:

This position reports directly to the Telemedicine clinic supervisor, and has primary responsibility for the daily operation of a Telemedicine Clinic. The Telemedicine Program utilizes systems designed for clinical episodes, but will also manage lower-end videoconferencing systems that will be used for administrative meetings and distance education. Thus, this position will be responsible for different levels of equipment usage. The incumbent will also assist with front office services which will include reception, scheduling, registration, authorizations and referrals, billing support, medical records, database creation, management, and report generation, and administrative support.

Purpose:

As Clinic Operations Coordinator, provide support for all activities involving specialty consultation services via telemedicine at various telemedicine consult sites throughout the Specialty Center Campus. Ensure that remote sites adhere to registration, referral authorization, delivery and evaluation protocols; collect data for analysis; provide support to physicians and other providers during consultations, and provide basic registration, billing, and database management and reporting services. Responsible for basic troubleshooting of video equipment as needed.

Duties:

**CLINIC ASSISTANCE AND PATIENT CARE COORDINATION**

- Answer referring physician questions appropriately and within the realm of knowledge/expertise, and expediently and appropriately relay the information to the proper clinician. Provide follow-through to ensure that all issues/questions are resolved.

- Serve as the primary contact for scheduling telemedicine consultations in the Main Hospital telemedicine suites. Act as a liaison between referring physicians, Specialty physicians, and clinic staff.

- Prepare main consult room and equipment prior to scheduled consults. Make sure successful video connection has been made, and stand-by during consult to provide technical assistance when necessary.

- Communicate with Telemedicine clinic staff regarding consult and patient schedules, and advise when changes are needed.

- Distribute clinic schedules, promotional material, documents, satisfaction surveys, and various items of information to on-site medical staff.

- Responsible for the smooth operation of the consult clinic. Duties include notifying specialist of upcoming appointments, printing daily patient schedules, gathering appropriate medical record information, and remaining on-site during consults to assist with unforeseen difficulties.
TELEMEDICINE SITE COORDINATOR SPECIALTY SITE, page 2

• Triage incoming telephone calls and appropriately handle each call by obtaining adequate information to make a proper telemedicine referral and schedule the teleconsultation.

• Responsible for patient registration, scheduling and billing activities for all patients seen via telemedicine. Prepare bills, check for completeness, and forward to billing personnel for processing. Reconcile reports and resolve discrepancies.

ADMINISTRATION


• Responsible for data collection, entry, and report generation utilizing database software.

• Assist in scheduling faculty coverage for telemedicine clinic.

• Participate in quality improvement and program development activities.

• Coordinate and participate in demonstrations upon request from Program Coordinator, Department Manager and Medical Director.

• Provide back-up coverage for clinic phones, and clinic-related activities at other Telemedicine consult suite sites on an as-needed basis.

• Other related telemedicine duties as defined by Clinic Supervisor.

TECHNICAL ASSISTANCE

• Independently troubleshoot minor technical difficulties, and escalate to technical staff when appropriate.

• Coordinate with the technical support team to ensure problems and system development needs are addressed.

SKILLS, KNOWLEDGE AND ABILITIES

• Excellent verbal and written communication skills, and the demonstrated ability to understand and to convey information clearly.

• Telemedicine clinic experience and Knowledge of various telemedicine technologies preferred.

• Experience working in or with a rural clinical setting with technicians, nurses and physicians preferred.

• Experience working in an academic clinical environment preferred.

• Experience working in or with correctional facilities preferred.
• Excellent computer skills and an ability to learn and understand the general technical requirements for the telemedicine systems.

• Ability to provide basic technical support and to triage more difficult problems to appropriate staff.

• Ability and skill to proficiently operate a PC for Excel, Word, Word Perfect, Access, Internet.

• Organizational skills to prioritize workload and meet deadlines, develop and carry-out project assignments in an efficient and timely manner and to provide accurate and succinct documentation of activities.

• Demonstrated ability to communicate effectively with physicians, clinical and technical staff.
• Ability to positively represent Specialty Center to external organizations and remote sites.

• Skill to exercise tact, courtesy and diplomacy when dealing with individuals at any level within or outside the Specialty Center.

• Ability to recognize relationship challenges with referring sites and specialists, and the ability to initiate appropriate action to resolve them.

• Analytical skills to independently and tactfully assume responsibility for coordination and completion of complex projects requiring interactions with many individuals in a matrix organizational structure.

• Skill and ability to analyze financial data and compile accurate reports to meet monthly deadlines.

• Ability to maintain confidentiality, exercise discretion, use independent and mature judgment, work without close supervision and commit to excellence.

• Ability to work with minimal direction and to take the initiative to follow-up on projects.

• Ability to work in an isolated environment without the assistance of team members for extended periods of time.


TELEMEDICINE INSTRUCTOR

TRAINING & USER SUPPORT

• Conduct classes and independent training sessions both on-site at the Specialty Center and at remote locations utilizing pre-established guidelines and curriculum

• Assess training needs and develop skill-appropriate sessions

• Prepare for users a comprehensive, clear, and understandable set of instructions describing system processes and user support processes as necessary to maintain and verify system operations.

• Assist in the preparation of technical documentation of the system for several levels of expertise: general users, system administrators, programmers.

• Document user questions and develop a log system to track technical problems and develop solutions

• Respond to phone and videoconference user questions in an organized and productive manner

• Assist Telemedicine Team members in deployment of multi-media presentations, oftentimes resulting in traveling to remote sites and overtime.

SYSTEM TEST AND INSTALLATION

• Plan and coordinate with user to develop validation, performance and acceptance criteria

• Through testing, identify and coordinate corrective modifications to the system

• Provide back-up for the Installer to ensure that implementation deadlines are met

SYSTEM DEVELOPMENT

• Provide technical assistance to other Development Team programmers and/or user analysts

• Coordinate directly with user management and other Team members during development phases

• Maintain knowledge of programming and analysis technologies as needed to design improved computerized systems

• Evaluate and suggest technologies/methodologies that may improve the development/support effort of the programming staff

• Participate in site visits to evaluate location and technology infrastructure needs

• Integrate various hardware components, as needed (e.g. CPU, monitor/s, speakers, microphone, cameras, scopes, VCR, scanners, printers) to develop clinical tools

• Update program W/O diagrams to reflect modifications
SKILLS, KNOWLEDGE, AND ABILITIES

- Ability to work as a team member with excellent communication skills necessary to effectively contribute to a creative group

- Demonstrated experience in creating and presenting oral and written material to large and small groups

- Ability to travel by car to remote locations, driving for up to 4 hours each way.

- Ability to work independently and to set and meet deadlines

- Demonstrated technical writing skills sufficient to communicate complex systems to diverse audiences

- Experience working in a clinical setting and demonstrated ability to communicate effectively with physicians and clinical staff

- Proven ability to train clinical and administrative staff who have various levels of technical expertise

- Ability to be focused to accomplish goals, but to be flexible and adapt to diverse situations

- Demonstrated organizational skills necessary to set and meet deadlines

- Ability to isolate and diagnose hardware and software problems in a LAN/WAN environment and to recommend and implement the most effective course of correction

- Experience with installation, configuration, maintenance, and trouble-shooting

- Knowledge of analysis and design techniques needed to understand user requirements and compose a functional computerized application system.

- Ability to use logic and flow diagrams to describe the functional processes of the system at a level that both end users and programmers can understand.

- Demonstrated comprehensive understanding of the capabilities and limitations of computers. Ability to recognize processes that can easily be automated and those that cannot.
TELEMEDICINE SPECIALTY SITE CLINIC MANAGER

This position reports directly to the Medical Director and has primary responsibility for the daily operation of the outpatient Telemedicine Clinics. This position is responsible for supervising the telemedicine clinic staff, for implementing new clinical contracts, for process improvement, and for coordinating with many specialty departments to ensure coverage for this "virtual" multi-specialty clinic.

CLINIC MANAGEMENT:

- Responsible for direct supervision of Telemedicine clinic staff.
- Act as liaison between customers (specialists and remote site referring physicians) and clinic staff to assure effective communication and efficient clinic operation.
- Assure all clinics are covered at all times (phone coverage and clinic coverage). Prepare annual employee evaluations for clinic staff.
- Provide coverage for clinic coordinators for sick and vacation leave, etc.
- Work with clinic coordinators, et al., to develop communication and program marketing activities to introduce new clinical services or increase referrals for specialty clinics on an as-needed basis.
- Supervise the design and maintenance of scheduling templates for clinic operations.
- Responsible for immediate decision making that would involve issues such as canceling clinics due to technical difficulties, releasing specialists due to patients not keeping their appointments, and/or for releasing contracted customers from specific payment responsibility (i.e. phone charges if appointments are missed or rescheduled).
- Prepare capacity projections by reviewing clinic productivity and collections reports. Based on these reports, and an understanding of new contracting opportunities created by business development activities, recommend specialty coverage needs. Reports must integrate volume and payer mix analysis. Responsible for specialty department negotiations and documentation of these agreements, as well as ensuring payment to specialty departments, in coordination with Finance team.
- Prepare and analyze monthly reports on wait-times for TM clinic appointments in each specialty to support capacity planning recommendations
- Oversee staff operations to assure all patients seen in the clinic are registered prior to the consult, and bills have been processed according to hospital Ambulatory Care standards. Assure all consults have been dictated, and dictation is received at remote site, as well as in the patient's medical record at the hospital site. Perform
- random audits at remote sites and in hospital Medical Records as part of the program's overall Clinical Quality Improvement activity. Assure timeliness of patient scheduling. Monitor and analyze clinic performance reports and make recommendations designed to improve or enhance clinic performance.
- Responsible for assuring clinics and coordinators are equipped with all necessary programs, computers, Information Services access needed to complete job duties. Responsible for assuring telemedicine equipment in each consult suite is adequate for the current need, as well as in reliable working order, and upgraded to meet current industry standards.
- From billing system, produce regular reports on billing and collection activities. Develop recommendations and solutions if issues are identified.
• Supervise abstracting and billing function of the billing analyst. Assure coding and billing activities are in compliance with Ambulatory Clinic standards for accuracy as well as timeliness. Work with clinic coordinators, physicians and billing analyst to minimize lag times.
• Perform billing and financial analysis, and provide recommendations regarding the budget as it pertains to purchasing or releasing specialty time.
• In partnership with Medical Director, act as primary contact and liaison to the professional billing group on behalf of center for all process and policy issues.
• Analyze insurance denial reports for process improvement. Work with professional billing group and/or clinic staff to determine further action (training of clinic staff or educating payers) to prevent reoccurrence.
• Audit patient database. Compare database with clinic schedule and billing reports to make sure invoices have been processed for all patients seen.

PROCESS IMPROVEMENT & CUSTOMER SERVICE QUALITY MAINTENANCE

• Work with technical team to automate as many clinic processes as possible. This includes resource scheduling, technical trouble-shooting, tracking of remote sites and their related technical information and personnel information, etc.
• Coordinate with the technical support team to ensure problems and system development needs are addressed. This includes tracking technical issues (e.g. closely monitoring trouble-shooting listserv) and jointly developing training opportunities and technical enhancements.
• Assess level of customer service for remote site coordinators by working directly with remote site coordinators and referring physicians. Act as primary point of contact for job performance feedback from remote site coordinators.
• Assess level of customer service for specialists. Work with team to poll all specialists on their satisfaction with the TM clinic operations, the quality of referrals from remote sites, as well as the quality of patient presentation. Notify instructor when training needs are identified.
• Provide organized feedback regarding operational issues and administrative matters to medical director, and make recommendations to facilitate further program development.
• From Excel spreadsheet received from billing group, prepare quarterly reports on collections by specialty, and collections by insurance provider. Produce quarterly collection reports for each specialty, comparing them to their department's overall collection ratio. Develop recommendations and solutions if issues are identified.
• Key member of department Clinical Quality Improvement meetings. Responsible for recommending, tracking and reporting on clinic-specific CQI measurements.
• Ensure that all regulatory and legal requirements are implemented in the unique telemedicine setting. Communicate with remote sites to ensure a clear understanding of the Telemedicine legal and regulatory environment (examples: JCAHO, HIPAA, reimbursement).
DATABASE MANAGEMENT

- Oversee the clinic database (necessary for clinic operations and health services research), including coordination with programming staff for necessary enhancements of the application to support clinic operations. Review activity on Referral Status web page. Work with remote site coordinators to make sure all their referrals are showing up on the web correctly. If problems exist with data not showing up on the web, determine whether it's a system or staff problem, and resolve accordingly. If the remote site doesn't have access to the web, make sure they receive their reports on a weekly basis.

- From Excel pivot table, prepare and analyze monthly reports on the following: Clinic volume by specialty; clinic volume by location; DNKA by site and specialty. Develop recommendations and solutions if issues are identified.

MISCELLANEOUS

- Act as back-up to lead instructor on an as-needed basis.

- Coordinate Public Relations communication to hospital departments and remote sites. Participate in demonstrations to visiting news media, government officials, as well as partner hospital administrators and physicians.

- Other related telemedicine duties as defined by the Telemedicine Operations Manager, Chief Administrative Officer, and Medical Director.

SKILLS, KNOWLEDGE AND ABILITIES

- Minimum of 2 years of recent hospital Ambulatory Care or clinic supervision experience required. Demonstrated ability to motivate staff to achieve optimal individual and team performance.

- Completion of Supervisor Series course desired.

- Demonstrated analytic ability to identify process or performance issues and develop recommendations using multiple information sources.

- Excellent verbal and written communication skills, and the demonstrated ability to understand and to convey information clearly

- Understanding of the legal and regulatory health care environment and analytic skills to implement policies in the unique telemedicine setting.

- Excellent computer skills and an ability to learn and understand the general technical requirements for the telemedicine systems. Ability to provide basic technical support and to triage more difficult problems to appropriate staff. Ability and skill to proficiently operate a PC for Excel, Word, Lotus Notes, Internet, Invision, Signature, and all hospital registration, scheduling and billing systems.
• Organizational skills to prioritize workload and meet deadlines, develop and carry-out project assignments in an efficient and timely manner and to provide accurate and succinct documentation of activities.

• Demonstrated ability to communicate effectively with physicians, clinical and technical staff.

• Skill to exercise tact, courtesy and diplomacy when dealing with individuals at any level within or outside the organization.

• Ability to maintain confidentiality, exercise discretion, use independent and mature judgment, work without close supervision and commit to excellence.

• Ability to work with minimal direction and to take the initiative to follow-up on projects.

• Ability to lead a team in a dynamic and highly visible unit, which requires a high degree of professionalism and flexibility.

• Ability to develop new operational processes and to teach these procedures to team members, to site coordinators, and to clinicians.
TELEMEDICINE TECHNICAL SUPPORT

Purpose:

The Telemedicine Program primarily utilizes systems and devices for the distribution and dissemination of healthcare services, education, and information. The program also investigates, integrates, and maintains videoconferencing systems for use by administration, education, and patient care activities. The primary responsibility of this position is technical investigation and support for the telemedicine program and its related activities.

Duties:

HARDWARE/SOFTWARE INSTALLATION CONFIGURATION AND MAINTENANCE

- Install, configure, test and maintain application systems, operating systems and communication software in a heterogeneous environment.
- Install, configure, maintain, and test video conferencing hardware/software including PCs, NICS, hard drives, and RAM.
- Install, configure and test software packages including operating environments, application suites and communication methodologies.
- Work with vendor technical support and corresponding departments to resolve outstanding issues, shipping, receiving, etc.
- Coordinate installation and test of circuits associated with data and video communications including, but not limited to, ISDN, Frame Relay, and T1.
- Plan, coordinate, implement and document user-validation, performance and acceptance of installed applications at remote and local sites.
- Identify, implement and document corrective modifications to ineffective or malfunctioning systems as appropriate.
- Set up and maintain training environments, presentations, laptops, etc. as appropriate.
- Other Hardware/software installation, configuration and maintenance duties as required.

SYSTEMS ANALYSIS, ADMINISTRATION, AND DEVELOPMENT

- Investigate, document, and implement application and data interchange and interaction processes to insure efficient and effective information and data access and utilization.
- Based on user needs and feedback, implement new, and update existing, desktop applications and ensure integration with enterprise applications, standards, and processes.
- Assist as necessary with the maintenance and upgrades of web, file and database servers.
- Implement new services as needed.
- Assist in the research, planning, documentation, and implementation of repairs, feature enhancements and future growth of information systems infrastructure.

USER SUPPORT

- Assist user and other team members in diagnosis and correction of problems encountered during and after implementation of systems or projects.
OTHER DUTIES

- Assist with the technical activities of the Technical Team as necessary.
- Assist in the documentation, management, and inventory of technical equipment, shipping and receiving, coordination of equipment moves, etc.
- Assist with the installation, testing, maintenance, and training of remote or field equipment, systems, and processes.

SKILLS KNOWLEDGE AND ABILITIES

- Ability to work as a team member with excellent communication and customer service skills necessary to effectively contribute to a creative group.
- Ability to work in a clinical setting and to communicate effectively with physicians and clinical staff.
- Demonstrated organizational skills and flexibility to manage multiple tasks and meet deadlines.
- Knowledge and understanding of videoconferencing equipment, processes, and protocols.
- Formal training and/or experience in trouble shooting and repair of computers and peripherals, including disassembly, board and chip replacement, continuity, cabling and cable testing.
- Ability to isolate and diagnose hardware and software problems in a LAN/WAN environment and to recommend and implement the most effective course of correction.
- Extensive PC hardware experience required including, but not limited to, configuration and installation of SCSI cards (all types), video cards, modems, network cards, motherboards and RAM.
- Perform IRQ and DMA troubleshooting and configuration.
- Must have experience with installation, configuration, maintenance, and trouble-shooting with a flavors of Windows & DOS. Linux experience a plus.
- Knowledge of TCP/IP utilities such as: FTP, telnet, ping, arp, rarp, etc.
- Knowledge of inverse multiplexors, ISDN, TI, and frame relay.
- In depth knowledge of MS Office Professional, and other office productivity software required.
- Comprehensive understanding of the capabilities and limitations of computers. Ability to recognize processes that can easily be automated and those that cannot.
- Knowledge of analysis and design techniques needed to understand user requirements and compose a functional computerized application system.
- Ability to use logic and flow diagrams to describe the functional processes of the system at a level that both end users and programmers can understand.
- Ability to work without direction in a networked computer environment. Ability to install and troubleshoot printers, other devices, relevant drivers and applicable software.
- Ability to manage small projects as appropriate.
Sample Workflows
Workflow varies from organization to organization. The following pages illustrate how a typical telemedicine clinic operates, and are intended to be used as a starting point in developing your own operational protocol. You will find differences and similarities between the duties of the patient site and the specialty site.

The flow charts illustrate how both the patient and specialty site clinics work together as a team to accomplish each patient consult. You will find your operational workflow to differ slightly, but the concept will remain the same.

The appointment scheduling flow chart was included in this document to give you an idea of the most common expectations for scheduling turn-around times. This chart has been used as a communication tool between the specialty site and the patient site, to establish realistic performance expectations.

The referral to billing process flow chart further illustrates the “back office” job duties of the telemedicine team. It also serves as a template for you to use when documenting your own work flow process within your organization.
DAY OF CONSULT - Patient Site
(Please refer to the flow chart for event timing and site participation requirement)

1. Telemedicine Coordinator gives their front desk receptionist the appropriate questionnaire packet to hand out when patient arrives (this may also be mailed to the patient prior to appointment). Patient should arrive 30 minutes prior to appointment if filling out a questionnaire is required.
   a. Patient must sign consent form (once per year).
   b. Patient must complete medical history form if not already done.
2. Telemedicine coordinator will prepare exam room and turn on telemedicine unit 30 minutes (or as early as possible) prior to the consultation. If peripheral equipment (derm camera, nasopharyngoscope, stethoscope, etc.) will be used during consult, please turn on and test image/sound prior to consult.
3. Fax completed history, and consent form, and any additional last minute test results to the Specialty site Telemedicine Coordinator.
   a. The specialist requires the completed history and questionnaire prior to the beginning of the consult.
4. Ask the specialist if he/she has received all the necessary information before rooming the patient.
5. Once the patient and the primary care provider are in the room, the site coordinator remains in the room to assist with the equipment as necessary.

AFTER THE VISIT - on the day of consult

1. At this time, the specialist may wish to send (via fax, or other electronic format) written instructions for the patient. Any written Instructions from the Specialist are to be copied and distributed. You may wish to ask the patient to move to the waiting room while waiting for the information.
   • Patient
   • Primary care provider
   • Patient medical record
2. Clean equipment if used (any cameras or scopes that have touched the patient).
3. If another patient is scheduled immediately following the previous appointment, ask the specialist “Are you ready for me to room the next patient?” before proceeding.

AFTER THE VISIT

1. Telemedicine Coordinator receives the specialist’s signed dictation, and places it in the referring provider’s box for review prior to filing in the patient’s medical record.

2. Telemedicine Coordinator reviews the consult dictation from the specialist. If a follow up appointment as well as any further tests are required, work with the primary care provider and the patient to complete the required tests, fax the results to the specialty site, and schedule a follow up appointment.
DAY OF CONSULT - Specialty Site

(Please refer to the flow chart for event timing and site participation requirement)

1. Telemedicine Coordinator receives electronically submitted information from the patient site, places it into the patient’s medical record, and places the medical record in the specialist’s box outside the consult room for review.

2. Telemedicine Coordinator asks the specialist if there is any other information he/she may need prior to the consult.

3. Consult begins. Telemedicine coordinator is not present in the room during specialty consults, but remains nearby in the event further information or technical support is needed.

AFTER THE VISIT - on the day of consult

1. At this time, the specialist may wish to send written instructions for the patient. Any written instructions from the Specialist are to be sent (either via fax or other electronic format) by the telemedicine coordinator to the referring site immediately following the consult, and placed in the patient’s medical record at the specialty site.

2. Collect specialist billing and dictation materials.

AFTER THE VISIT

1. After the specialist reviews and signs the dictation, send the original to the referring physician (either via mail or electronic transmital), and place a copy in the patient’s medical record.

2. Telemedicine Coordinator reviews the consult dictation from the specialist. If a follow up appointment as well as any further tests are required, work with the patient site coordinator to schedule the appointment after the tests have been completed and received.
PRIOR TO CONSULT

SPOKE SITE
PRIMARY CARE PROVIDER

ORDERS ADDED TESTS, ETC., IF APPROPRIATE
EXPLAINS TELMEDICINE TO PATIENT

SEES PATIENT, DETERMINES SPECIALTY CONSULT IS

TM NO

TM UNSURE

SPoke SITE TELMEDICINE COORDINATOR/FRONT OFFICE STAFF

GIVES PATIENT CHART AND REFERRAL TO TM COORDINATOR

HUB SITE CLINIC COORDINATOR

OBTAINS REFERRAL AUTHORIZATION NUMBER

FAXES HUB CLINIC REFERRAL AUTHORIZATION NUMBER, PATIENT REGISTRATION INFORMATION, PATIENT CHART NOTES, AND REASON FOR CONSULT.

TM NO

Determines whether condition is appropriate for video consult and requests additional test, etc., if appropriate.

FORWARDS TO SPECIALTY CONSULTANT FOR REVIEW

TM YES

SCHEDULES VISIT AND NOTIFIES PATIENT OF APPOINTMENT DATE AND TIME.
SCHEDULES CLINIC ROOM AND SCHEDULES PCP IF APPROPRIATE.

FAXES HUB CLINIC REFERRAL REQUEST (INCLUDING REASON FOR CONSULT) WITH CHART NOTES TO SPECIALTY CONSULTANT FOR REVIEW.

TM NO

EXPLAINS TELMEDICINE TO PATIENT.
GIVES PATIENT CHART AND REFERRAL TO TM COORDINATOR.

SCHEDULES CLINIC ROOM AND SCHEDULES PCP IF APPROPRIATE.

ORDERS ADDITIONAL TESTS, ETC., IF APPROPRIATE.

TM NO

TM UNSURE

HUB SITE SPECIALTY CONSULTANT

PrioR TO CONsuLt
**Day of Consult**

**SPOKE SITE PRIMARY CARE PROVIDER**

- Patient arrives 30 min prior to consult, and is issues the following paperwork to complete:
  - Consent form
  - Medical History form (if appropriate)

**SPOKE SITE TELEMEDICINE COORDINATOR/FRONT OFFICE STAFF**

- Completed paperwork is faxed to Hub site clinic coordinator
- Video equipment is turned on and call is placed

**HUB SITE CLINIC COORDINATOR**

- Prepared consult desk:
  - PCP transmittal (reason for consult)
  - Patient chat notes, medical history, & consent forms
  - Billing form

- 20 Minute prior to consult spoke site initiates video call to Hub site.

**HUB SITE SPECIALTY CONSULTANT**

- Consultant arrives 15 min early to review patient information
- Consultant begins on-time
- *Complete treatment plan
- *Dictate progress note

**PCP participates in patient presentation/physical exam when "medically necessary**

**Complete Billing Form**

*Administer patient satisfaction form
*Distribute treatment plan
*Clean equipment
*Schedule follow-up appt, if appropriate.

*Fax treatment plan to Spoke site
*Schedule follow-up (on-site or video) if appropriate
*Process billing and progress note transcription
SPECIALTY CLINIC APPOINTMENT SCHEDULING FLOW CHART

**DAY 1**
- Completed demographics form and all necessary patient chart notes, test results, etc.
- Is the specialty requested and established telemedicine specialty?
  - No
    - Forward demographics and chart notes to Clinic Supervisor
  - Yes
    - Is the patient presenting with a pre-approved "Clinical Condition"?
      - Yes
        - Is the specialty requested offering regular TM clinic appointment slots?
          - Yes
            - Schedule into next available appointment slot
          - No
            - Telephone and/or email Specialist to request appointment time
        - No
          - Escalation Procedure: If 48 hours have passed since receipt of complete patient information (demographics and chart notes) and an appointment has not been scheduled, please contact TM Specialty Clinic Supervisor.
      - No
        - Escalation Procedure: If 48 hours have passed since receipt of complete patient information (demographics and chart notes) and an appointment has not been scheduled, please contact TM Specialty Clinic Supervisor.

**DAYS 2-10**
- Approved for Telemedicine?
  - Yes
    - Specialist offers date and time for appointment
      - Schedule patient
  - No
    - Spoke site coordinator is notified

**DAYS 2-15**
- Clinic Supervisory either a) Independently determines appropriate specialist to contact; or b) reviews chart notes with Medical Director who suggests appropriate specialist(s) to contact
- Approved for Telemedicine?
  - Yes
    - Specialist offers date and time for appointment
      - Schedule patient
  - No
    - Forward Demographics and chart notes to specialist for review, and conduct TM demo for specialist if requested
      - Escalation Procedure: If 15 days have passed since receipt of complete patient information and an appointment has not been scheduled, or you have not received a satisfactory explanation for the delay, please contact Telemedicine Manager. If no response in 24 hours, contact Medical Director.

**Important Note:** If at any time it is determined patient chart is incomplete (ie, labs, x-rays, etc are missing, or additional information is needed), the remote site coordinator will be contacted immediately and status of referral will revert to beginning of process in Day 1 once all necessary information is received.
TELEMEDICINE REFERRAL TO BILLING PROCESS

Remote Site

Remote site physician identifies need for referral to specialist

Specialty Site Telemedicine

Remote site coordinator obtains insurance authorization (as needed), gathers paperwork according to specialty referral guidelines and completes referral form

Intake Specialist

Remote site coordinator faxes referral form and patient paperwork according to specialty referral guidelines, and insurance authorization (as needed)

Specialty Site Telemedicine

Intake specialist receives referral and patient paperwork

Specialty Site Telemedicine Coordinator

Intake paperwork completed?

Specialist

See patient

Specialty Site Billing Analyst

Receive specialist encounter form, documentation, consent and HIPAA forms from coordinator

Remote site coordinator obtains insurance authorization (as needed), gathers paperwork according to specialty referral guidelines and completes referral form

Intake specialist receives referral and patient paperwork

Intake specialist paperwork completed?

If no, contact remote site coordinator to obtain missing documentation.

If yes, is specialist available?

If no specialist is available, intake notifies remote site coordinator and enters patient information in to database only

Specialty Site Telemedicine Coordinator

Confirm receipt of necessary patient paperwork or call remote site to obtain

Specialist

Dictate recommendations

Specialty Site Billing Analyst

Receive specialist encounter form, documentation, consent and HIPAA forms from coordinator

Fax/Mail dictation to remote site physician

Specialty Site Telemedicine Coordinator

Confirm receipt of patient file from intake specialist or call to obtain file

Specialist

Return patient file and documentation to coordinator and inform them if follow-up appointment is needed

Specialty Site Telemedicine Coordinator

Call remote site coordinator to coordinate/confirm appointment time

Specialist

Abstract (code) and bill physician consultation

Specialty Site Telemedicine Coordinator

Schedule patient in scheduling system and database

Specialist

File physician encounter after billing is complete

Specialty Site Telemedicine Coordinator

Provide physician with patient file on day of appointment

Specialist

Edit and sign dictation

Specialty Site Telemedicine Coordinator

Receive patient file from specialist. Notate if follow-up patient appointment is needed and inform remote site.

Specialist

Send specialist encounter form, documentation, consent, and HIPAA form to Billing Analyst

Specialty Site Telemedicine Coordinator

Create patient file and deliver to Telemedicine coordinator

Specialty Site Telemedicine Coordinator

Receive specialist encounter form, documentation, consent and HIPAA form to Billing Analyst

Specialist

Mail specialist documentation, consent and HIPAA to medical records
Introduction

Room design impacts the quality of the telemedicine services and should not be overlooked during the development of a telemedicine program. Good telemedicine room design will accomplish two major functions: it will create the visual and audio clarity and accuracy that is necessary to support clinical examination and diagnosis from a distance and a connection between the patient and the remote provider sites where the patient-clinician interaction, not the technology, is the focal point.

This document provides practical information and advice on the major components that need to be addressed in designing a telemedicine room. It will assist in selecting the best room for providing telemedicine services and identifying modifications that need to be made in the selected room. This guide includes a template that can be used in assessing the design of your telemedicine room. While the guide focuses on patient examination rooms, the same fundamentals apply to remote clinician rooms. A companion video is available at www.caltrc.org.

Design Considerations

The challenge in creating a telemedicine room is to integrate the technology into the regular flow of an examination and to reproduce the images at the consulting clinician site with clarity and accuracy. There are a number of aspects to consider when designing a telemedicine exam room. The most important design considerations are:

- Room Location
- Room Size
- Placement of Equipment and Furniture
- Electrical and Telecommunications Connections
- Lighting
- Acoustics
- Wall Color

Since most patient sites will be adapting an existing room for telemedicine, it is important to select the best possible fit and to budget, if necessary, for room modifications.
**Room Location**

The telemedicine room should be in a quiet location, minimizing exposure to office noise, busy corridors, stairwells, parking lots, waiting rooms, restrooms or other sources of noise. Such noise can be picked up by microphones which can make it difficult for the remote site to hear. Rooms without windows are better for quality image transmission. Rooms with windows should have shades or blinds to reduce the light and glare.

**Room Size**

While there are no specific room size requirements, the optimal room size depends on the service being provided, as well as the type and size of the equipment in use. For example, clinical or patient education programs will require conference seating for many participants while specialty consultations will require examination on tables and room for only a few people.

**Telemedicine Patient Examination Room:** A telemedicine exam room should be large enough to move around and work with patients comfortably. It should be large enough to accommodate an examination table, a couple of chairs, the telemedicine equipment, the patient, and the patient presenter. The patient should be able to sit in a chair as well as use the examination table; both should be within the cameras view. There should be enough room to easily use the telemedicine scopes and for the patient presenter to move around the patient during the examination. Most exam rooms should also contain a work surface for charting, a phone, a computer and when necessary, a fax machine available nearby.

The size of the room also impacts the camera viewing area. The distance between walls will determine the proximity of the camera and microphone to the patient. Ideally, the telemedicine camera should be located 6 - 8 feet from the patient. The camera needs to be able to pan out to a full view of the room with the patient and the patient presenter in the picture, and zoom in to have close-up views of the patient. A small room forces the camera to be located too close to the patient, limiting the consulting clinician's view.

**Remote Clinician’s Consultation Room:** The remote clinician also needs to consider room design. The room design factors that impact a patient exam room generally impact the remote clinician’s site as well. Room size can be smaller for a remote clinician site since the patient exam table is not necessary. They also need to consider the camera viewing area and angle of the camera, which is discussed under the Equipment Placement Section.

**Clinical Education Rooms:** Many telemedicine programs offer clinical education programs for clinicians or for patients. A well designed education room would follow guidelines for classroom development, which would include writing tables for attendees, lecterns, and white boards for the walls. From a videoconferencing perspective, the challenges are adequate audio feeds, camera coverage, and size of the viewing monitor. Many patient sites use the patient examination room to view clinician education programs. While this may be a necessity if a unit cannot be moved to a conference room, attendees may find this uncomfortable and it can impact the overall acceptance of the technology. Some programs install lines in both an examination room and a conference room to facilitate education programs. The small screen commonly used in an exam room may not be appropriate for viewing in a conference room. Early planning and budgeting can result in solutions that accommodate both needs.
Equipment Placement

Once an appropriate room has been located it will need to be evaluated for placement of the telemedicine equipment. The goal of placement is to optimize the camera’s view of the patient, to allow staff to enter and exit without interrupting the visit, and to allow the presenter to easily use the scopes and peripherals. As you begin to consider placement of equipment, it may be helpful to create a drawing of the room with doors, windows, electrical outlets, and existing telecommunication connections.

Positioning the Exam Table: The camera and exam table should be positioned so the patient presenter can see both the patient and the monitor when using scopes that transmit images to the remote clinician site. There should be a place for a chair which is often used for the patient at the beginning and end of the visit. A second chair should be available, should a family member be in attendance during the visit.

The exam table or patient chair should not be placed in front of a window because backlighting can degrade the patient image at the remote clinician site. Shades or blinds generally can not reduce backlighting enough to be acceptable. The remote clinician should also not be placed in front of a window unless the backlighting can be adequately addressed to allow the patient a clear view of the clinician.

Clean and Uncluttered

An uncluttered background optimizes camera function and improves the view at the remote site. Wires, telephones, fax machines, monitors, computers, peripheral equipment and furniture can contribute to a cluttered and inefficient workspace. Make an effort to arrange and store them in an organized, efficient way.
Positioning the Camera: Cameras need to be placed so that both participants are looking directly at each other during a video call. If the camera is placed too close to the participant or mounted too high above the monitor, the person appears to be looking down at the monitor rather than directly at the remote participant, as shown in Figure A. This can occur at either the patient or the remote clinician side of the connection. The remote clinician site needs to be particularly aware of this effect when using a desktop computer with a camera mounted on top of the monitor. The distance can be too short resulting in the clinician looking down all the time. Correct camera positioning is shown below in Figure A.

Figure A: Impact of Camera Placement

Even though the patient is looking directly at the consultant, it does not appear that way because the camera is mounted too high. Mounting the camera too high makes it difficult for the consultant and patient to maintain eye contact.

When the camera is mounted at approximately the same height as the patient it produces a more precise view of the patient, allowing the patient and consultant to make eye contact.

Electrical and Telecom Outlets: Telecommunications and electrical outlets should be installed or expanded based on the best location for the exam table and telemedicine unit. Locating the telecommunications outlets near the unit will avoid long runs of cable on the floor. Depending on the complexity of equipment multiple outlets may be required for your equipment. Generally, a standard 120v outlet with a surge protector is appropriate for telemedicine equipment.
Lighting

Lighting is perhaps the most critical factor in designing a telemedicine examination room. Lighting impacts the clinician’s ability to see the patient clearly with true color reproduction, which is critical for patient evaluation. The goal of lighting is to create images that have even lighting and accurately reproduce colors - where the images are not too dark, and do not have shadows.

Telemedicine programs sometimes fail to fully address lighting requirements assuming the camera will be able to correct for any lighting problems. The telemedicine camera alone will not be able to compensate for poor lighting systems. In fact, good lighting will dramatically improve image quality even when using less expensive cameras.

Optimal Lighting

Optimal lighting is a diffused light source that does not create shadows and depicts colors accurately. Ideally, the telemedicine examination room will have both direct and indirect lighting. A good source of diffused light is needed in front of the patient shining diagonally toward the patient. Placing a light source in front of the patient reduces shadows that occur on the face if only overhead lighting is used or if there is a light source behind the patient. Spotlights or harsh directional lighting can create unwanted shadows, as shown in below Figure B.

Lighting Fundamentals

- Use diffused soft light falling in front of the patient
- Avoid backlighting from windows or overhead lights
- Avoid harsh lighting sources
- Consider full spectrum lighting
- Use supplemental lighting when necessary

Windows or other light sources behind the patient can cause deep shadows on the face that interferes with clinical evaluation as shown above in Figure C.

Figure B: Impact of Harsh Directional Lighting
Most patient examination rooms have overhead fluorescent lighting as the standard lighting configuration. Fluorescent overhead lighting alone may not provide optimal lighting for telemedicine clinical visits. They can provide excellent diffused light if the tubes can be placed in front of the patient. An additional source of light may be needed because fluorescent lighting can create washed out images. Full spectrum fluorescent light tubes can also be purchased to support accurate color transmission.

Special lighting needs should also be considered to assure that images have adequate color reproduction, contrast, and definition. Dermatology, in particular, requires accurate color reproduction which may not be achieved when relying solely on ceiling mounted fluorescent lighting, as shown below in Figure D. A supplemental light source may be necessary to obtain accurate color reproduction. The image on the right of Figure D shows the same subject with additional lighting from a supplemental light source. (Please note that color accuracy is also affected by the white balance of the camera or peripheral scopes.)
Wall color

Wall color also impacts how patients look on video. White or light walls can darken faces, making features hard to see at the remote site. A dark wall color can lighten faces. This occurs because automatic aperture settings on video and still cameras react to the wall color. If the wall is light, the camera lets in less light resulting in darkened faces. If the wall is dark, the camera lets in more light making the faces become washed out or too light. Use flat paint to avoid any reflection off the wall. Figure E demonstrates the difference between light and dark-colored backgrounds.

As illustrated in Figure F, a robin's egg blue or light gray background works well on all skin tones. It can be very helpful to test the selected color before painting the entire wall. Different lighting conditions will affect the shade of the color. Seeing the color on the remote end can help select the color that best suits the room. It is not necessary to paint the entire room the selected color. It can be limited to the walls that will be the backdrop for the camera views. This may include more than one wall depending on the configuration of the room.

Figure E: Impact of Wall Color

A light-colored background makes the image appear too dark.

A dark-colored background makes the image appear washed out or too light.
Acoustics
Good acoustics design is also important to consider. Rooms that echo make conversation between the patient and remote clinician difficult. High ceilings and hard surfaces on floors and walls can create poor acoustics as can noises from facility mechanics and external sources. Installing materials that absorb or dampen sound will improve the acoustics of the room. Sound dampening is usually achieved by installing carpeting, drapes, tiles or paint. Since a clinic setting does not lend itself to carpeting or drapes, acoustic tiles can be installed on the ceiling or around the top of the walls.

Sound dampening wall paint is also available. Be sure to check on any facility licensing requirements before selecting a sound dampening solution. The remote clinician’s room may be able to use carpeting and drapes if the room is not used for patient examinations.

It is important to consider the amount of outside noise when selecting a room because it can be difficult to reduce the level of noise that enters the room and it can become disruptive to patient visits. Unwanted noise from within the room often is the result of fans used to keep the telemedicine equipment cool. Fan noise can be reduced by installing the equipment inside a cart or case; however, any case needs to assure proper air flow or the equipment can overheat and be damaged.

Mobile Considerations
Telemedicine mobile units are becoming increasingly popular for disaster response and mobile clinics to reach migrant or remote populations. When setting up a mobile telehealth vehicle, be sure to consider the same key areas discussed for room design. Placement of equipment, lighting, and acoustics become an even bigger issue when your patient site has to be changed or moved regularly. Some mobile programs do not have a telehealth equipped vehicle and move equipment from location to location, setting up upon arrival. Consider using the checklist in this guide each time the site is set up to ensure the success of the consultation. It may also be helpful to use one or two standard floor configurations for setup.
# Telemedicine Room Assessment and Design Worksheet

**Type of Telemedicine Room:**
- [ ] Patient exam
- [ ] Remote clinician
- [ ] Education / classroom

What type of clinical services will be provided:

______________________________________________________________________________________________

______________________________________________________________________________________________

Are there any special spaces or lighting considerations related to the services:

______________________________________________________________________________________________

______________________________________________________________________________________________

Name of room selected for assessment:

______________________________________________________________________________________________

### Room Location:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### Room Size:

Identify the equipment that will be needed in this room.

- ☐ Telemedicine unit - specify size:_____
- ☐ Exam table
- ☐ Patient chair
- ☐ Other chairs – number:_____
- ☐ Work table
- ☐ Desk
- ☐ Computer
- ☐ Specialized lighting – specify type: ______
- ☐ Peripheral equipment
- ☐ Telephone
- ☐ Fax machine
- ☐ How many people does the room need to accommodate:_____

Yes No
- ☐ Room is large enough to accommodate needed equipment with adequate room for the patient presenter to comfortably move around

### Equipment Placement:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Modifications that will be required:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Yes No

- ☐ Estimated cost of modifications:______________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________
Lighting:
Yes No

- ☐ No windows in the room
- ☐ If the room has windows, can shades or blinds mitigate impact of lighting
- ☐ If the room has windows, can the exam table be placed to avoid backlighting
- ☐ If the room has windows, can the exam table be placed to avoid backlighting
- ☐ Lighting provides adequate direct and indirect lighting
- ☐ Direct light source shines diagonally toward the patient
- ☐ Supplemental lighting adequate
- ☐ Full Spectrum light bulbs are needed

Modifications that will be required: _____________________________________________________________
___________________________________________________________________________________________

Estimated cost of modifications: _______________________________________________________________
___________________________________________________________________________________________

Room Color:
Yes No

- ☐ Paint color is appropriate for telemedicine
- ☐ Paint finish is flat

Modifications that will be required: _____________________________________________________________
___________________________________________________________________________________________

Estimated cost of modifications: _______________________________________________________________
___________________________________________________________________________________________

Acoustics:
Yes No

- ☐ Room has minimal outside noise
- ☐ Room does not echo
- ☐ Equipment noise levels are minimal
- ☐ Facility license requirements allow modifications

Modifications that will be required: _____________________________________________________________
___________________________________________________________________________________________

Estimated cost of modifications: _______________________________________________________________
___________________________________________________________________________________________

Clean and Uncluttered Room:
Yes No

- ☐ Area is clear of clutter

Total estimated cost for room modifications: ____________________________________________________
tab 4 goes before page 98
DEVELOPING A TELEHEALTH MARKETING PLAN:
A Step by Step Guide

CALIFORNIA TELEHEALTH RESOURCE CENTER
Your resource for telehealth success
This Marketing Plan is designed as a template that can be easily taken and adopted to suit the needs of a hospital or clinic which is the recipient of telehealth services that it can provide to its community.

There are multiple ways to put together a marketing plan. Some plans can go into a lot of traditional market research and analysis such as segmentation, targeting, positioning, the 4 P’s (product, price, place, promotion), etc.

This plan does not take that approach because it can be too complicated and time consuming for professionals whose primary job is not actually marketing, but who need to generate and execute effective marketing strategies to drive telehealth awareness, increase its utilization, enhance its reputation, and ultimately drive growth.

So instead, we opted for a clear, simple way to help someone like a telemedicine director develop a marketing plan.

The plan assumes that XYZ Regional Medical Center has already gotten approval to start a telehealth program. Therefore, the marketing plan is (and should be) but one major element of the broader plan for successfully implementing the telehealth program.

This plan template is designed to help someone explain what they plan to do from a marketing perspective, why they want to do it, and how they will measure the results.

Someone could essentially take the goals, target audiences, marketing activities, success metrics, and economics in this plan; customize these for their particular situation, and have a marketing plan ready to go.
MARKETING PLAN COMPONENTS

This portion of the document describes the main sections that you should have in your marketing plan. When all of these components are present, the reader should have a good sense of how the marketing strategy and its execution come together. You can use the descriptions in these sections to create your own marketing plan from scratch. Whenever you get stuck, you can also look at the Sample Marketing Plan later in this document and copy/modify text to suit your specific needs.

EXECUTIVE SUMMARY
This section is for someone (e.g. an “executive”) who does not have time to read the entire marketing plan. It enables them to scan the key details of the marketing plan:

• What are our goals?
• Who are we targeting?
• What is our budget?
• What do we plan to do with it?
• Are there any major activities or items worth noting?
• How will we measure success?

INTRODUCTION
This is a brief section that explains what the Marketing Plan will cover.

BACKGROUND
This section gives context to the Marketing Plan. Describe the circumstances under which these marketing activities will take place, what has been accomplished, and what product or service is being offered. These descriptions put the marketing plan in a business context, so that it is not a stand-alone effort.

STRATEGIC OBJECTIVES
While the previous section provided the business context, this section lays out specific strategic goals that can be measured. These goals should relate to the telehealth product or service you are offering. It is helpful to group related goals into categories like “business” and “clinical.” Ultimately, the operational, marketing, and technical plans will support these primary goals.

For the business goals, outline any goals that apply in the following areas: Financial, Market Share, Market Leadership, Reputation, Facility’s Mission, Operational effectiveness. Where possible, identify when these goals should be achieved and how the metrics for success will vary from one year to the next.

For clinical goals, outline any goals that apply to: Patient care, Clinical support and participation.

MARKETING OBJECTIVES
Describe the key objectives of the marketing plan. Just as with the broader strategic objectives, include success metrics for each marketing objective.

MARKETING STRATEGY: OVERVIEW
This section is simply for overviewing the major elements that will go into the marketing strategy. They will be detailed in subsequent sections and provide market analysis to back up your strategic direction.

In the classical approach taught in business schools, these major elements would be “Segmentation”, “Targeting”, and “Positioning”. Another option is to go with “Market,” “Message,” and “Media.” Whatever you pick will drive other sections of the marketing plan.
MARKET ANALYSIS: TARGET MARKET
How did we divide up the market of people we want to speak to? Who do we want to speak to? Who are the targets of our marketing campaigns? Why have we selected these targets versus others?

MARKET ANALYSIS: PROBLEMS, ALTERNATIVES, TELEHEALTH SOLUTION BENEFITS
Having selected the marketing targets, the next step is to figure out what we want to speak with them about. Before making the mistake of jumping right into a discussion of telehealth, identify their specific challenges and the options they have for addressing these challenges. Then identify the unique benefits that telehealth can bring by resolving the challenges in ways that the other alternatives do not. Ensure that the analysis is specific to each target market. A generic analysis is likely to fall flat because it does not dive deep enough into the specific issues for any one targeted group.

MESSAGE
Bring the elements from the Market Analysis together into guiding messages that can be used in marketing materials. This is where you get closer to “copy” – the actual words that will be used in your marketing materials. How do we want to attract our target? How will we differentiate our offering? What claims will we make (that we can justify)? Because this solution is in healthcare, be careful that your claims are defendable. In other words, you cannot guarantee patient outcomes, but you can promote the solution as having demonstrated certain outcomes.

RESOURCES
Identify the resources available to support various marketing activities. Resources can be team, financial, etc. Any changes in these could affect the ability to execute on time, within budget, or in a way that achieves targeted goals.

MEDIA
Identify the means by which we will reach our target audiences with our message. Explain why specific activities have been chosen over others.

MARKETING ACTIVITIES: SUMMARY
Provide a summary of the key marketing activities. Include information on each activity that could be easily compared across activities. These can include: Description, Objectives served, Target audiences, Frequency, Metrics for success, Resources involved, and Budget.

MARKETING ACTIVITIES: DETAILS
For specific marketing activities that require more details, provide them in this section. For example, for a website, include more info about the content that it could include.

SUCCESS METRICS
Marketing activities should produce measurable results. This is the section for describing how each marketing activity will be rated in terms of success. While the Marketing Activities Summary will identify success metrics each individual activity, this section will aggregate all success metrics across these activities (as some metrics will be served by multiple activities). In addition, identify the targeted value of these metrics and the various activities that contribute to each metric.

FINANCIALS
Summarize the financial outlay for the marketing plan. Break it out in different ways if possible – by month, by activity, by capital costs vs. operating costs.
# SAMPLE MARKETING PLAN: XYZ REGIONAL MEDICAL CENTER

## Executive Summary ................................................................. 2
## Introduction ............................................................................... 3
## Background ............................................................................... 3
## Strategic Objectives ................................................................. 4
  - Business .............................................................................. 4
  - Clinical ............................................................................... 4
## Marketing Objectives ............................................................... 5
## Market Strategy: Overview ........................................................ 5
## Market Analysis: Target Market ............................................... 6
## Market Analysis: Problems, Alternatives, Telehealth Solution Benefits ................................................. 7
  - Hospital Administration & Staff ........................................... 7
  - Referring Providers .............................................................. 8
  - Patients ............................................................................... 8
  - Supporting organizations: Employers .................................. 9
  - Supporting organizations: Churches and Charities ............... 9
## Message ................................................................................... 10
  - Sample headlines ............................................................... 10
## Resources ................................................................................ 11
  - Team ................................................................................ 11
  - Financial ............................................................................ 11
## Media ....................................................................................... 11
## Marketing Activities ................................................................. 12
## Marketing Activity Details ....................................................... 14
  - Website ............................................................................... 14
  - Newsletter ......................................................................... 14
  - Brochure ........................................................................... 15
  - Press releases / Guest articles in newspapers ....................... 15
  - Connected Health Media Day ................................................ 15
  - Satisfaction Survey .............................................................. 15
  - Social Media ..................................................................... 15
  - Face-to-face visits .............................................................. 15
## Success Metrics ....................................................................... 16
## Financials .................................................................................. 17
EXECUTIVE SUMMARY

This section is for someone (e.g. an “executive”) who does not have time to read the entire marketing plan. It enables them to scan the key details of the marketing plan:

..... What are our goals?
..... Who are we targeting?
..... What is our budget?
..... What do we plan to do with it?
..... Are there any major activities or items worth noting?
..... How will we measure success?

XYZ Regional Medical Center’s Marketing Plan is designed to increase the visibility, adoption, and use of our new telehealth services. Our marketing campaigns will primarily target:

• the patient community
• referring providers
• internal administration and staff

With an operating budget of $1,550 for the year ending in December, we will accomplish the following:

• Website and eNewsletter
• Brochures
• Press releases and Guest articles in the media
• Connected Health Media Day
• Satisfaction surveys from patients, providers, and administration
• Social media presence
• Face-to-face visits
• Attend a regional conference to pick up best practices for accelerating program growth.

The largest cost items will be the Connected Health Media Day and attendance of the CTN Conference.

The top measures of success for the marketing plan will be:

• # Website visitors. Target: 1,000
• # Newsletter subscribers. Target: 250
• Patient satisfaction score. Target: 90%
• % of Administrators that can identify at least 3 telehealth benefits. Target: 75%
INTRODUCTION
This document describes the Marketing Plan for XYZ Regional Medical Center’s telehealth program.
It covers marketing strategy, marketing tactics, success metrics and financials.
All major marketing activities are summarized and described in the Marketing Activities section for quick reference.

BACKGROUND
This section gives context to the Marketing Plan. Describe the circumstances under which these marketing activities will take place. Describe what has already been accomplished, and what product or service is being offered. All of these descriptions put the marketing plan in a business context, so that it is not a stand-alone effort.

XYZ Regional Medical Center (XYZ RMC) has recently committed to participate in the California Telehealth Network (CTN). It will be utilizing CTN’s services to provide patients in Alphabet County with a new suite of clinical services via telehealth.
These telehealth services will include both emergency and non-emergency services:
• NON-EMERGENCY SERVICES
  Cardiology
  Dermatology
  Gastroenterology
  Infectious Disease
• EMERGENCY SERVICES
  Neurology / Stroke
Telehealth technology for broadband services and video-conferencing was originally obtained through grant funding from Generous Organization of America.
STRATEGIC OBJECTIVES

While the previous section provided the business context, this section lays out specific strategic goals that can be measured. These goals should relate to the telehealth product or service you are offering. It is helpful to group related goals into categories like “business” and “clinical”. Ultimately, the operational, marketing, and technical plans will support these primary goals.

We want to encourage participation in this network so that XYZ RMC sees a return on its new investment and ultimately provides better care to our patient population.

BUSINESS
Outline any goals that apply in the following areas: Financial, Market Share, Market Leadership, Reputation, Facility’s Mission, Operational effectiveness. Where possible, identify when these goals should be achieved and how the metrics for success will vary from one year to the next.

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hospital’s CEO, CMO, and CTO should be able to identify the top benefits that the program is bringing to the medical center.</td>
<td>Within 6 months of program launch</td>
</tr>
<tr>
<td>3 external organizations in the local community will have recommended the service to their members.</td>
<td>Within the 1st year</td>
</tr>
<tr>
<td>Patient satisfaction with telehealth program will exceed 90%</td>
<td>Within the 1st year</td>
</tr>
<tr>
<td>Positive media coverage about the telehealth program</td>
<td>Within 6 months of launch</td>
</tr>
<tr>
<td>Measurable Return on Investment (ROI)</td>
<td>Within the 1st year</td>
</tr>
</tbody>
</table>

CLINICAL
Outline any goals that apply to: Patient care, Clinical support and participation

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve 100 telehealth encounters.</td>
<td>Within the 1st year</td>
</tr>
<tr>
<td>10 clinicians will obtain training on telehealth and on topics related to the supported telehealth specialties, and earn CE credit.</td>
<td>Within the 1st year</td>
</tr>
<tr>
<td>Change at least one patient’s life by reducing wait time significantly, enabling them to avoid taking time off of work to see a specialist, or helping them to get a diagnosis that alters their outcome.</td>
<td>Within the 1st year</td>
</tr>
<tr>
<td>Clinician satisfaction with telehealth program will exceed 80%</td>
<td>Within the 1st year</td>
</tr>
</tbody>
</table>
MARKETING OBJECTIVES

Describe the key objectives of the marketing plan. Just as with the broader strategic objectives, include success metrics for each marketing objective.

In support of the program’s broad objectives, our telehealth marketing efforts are designed to:

• **Increase visibility and awareness** of our new telehealth services both internally and within our community

• **Drive internal support** for the program. Administrators will continue funding it and advocating its use. Physicians, nurses, and other clinicians will make use of the system.

• **Drive utilization** of our new services both by patients and referring providers.

• **Grow reputation** through media coverage, testimonials, and success stories.

Specific measures of success are outlined along with the selected marketing activities/campaigns in the section entitled “Success Metrics.”

MARKET STRATEGY: OVERVIEW

This section is simply for overviewing the major elements that will go into the marketing strategy. They will be detailed in subsequent sections and provide market analysis to back up your strategic direction.

In the classical approach taught in business schools, these major elements would be “Segmentation,” “Targeting,” and “Positioning.” Another option is to go with “Market,” “Message,” and “Media.”

Whatever you pick will drive other sections of the marketing plan.

Our marketing strategy is designed around addressing these 3 key elements:

• Market – who do we want to speak to?

• Message – what do we want to tell them?

• Media – how do we want to get our message across?

We will choose our market, message, and media based on the analysis in the next few sections.
MARKET ANALYSIS: TARGET MARKET

How did we divide up the market of people we want to speak to? Who do we want to speak to? Who are the targets of our marketing campaigns? Why have we selected these targets versus others?

We identified numerous groups that could influence the awareness, use, and reputation of the telehealth program (FIGURE 1). In the figure, the larger the rectangle, the larger the potential influence. The directions of the arrows indicate the direction of influence. Based on this analysis, we see that the Telehealth Director has potential to influence a number of other influencers as well.

Although not illustrated, a number of entities also influence the Patient’s decision to accept and use telehealth as an alternative to their current means of receiving healthcare. These are the various Referring Providers; Supporting Organizations like employers, churches, and charities; and the media.

For our initial marketing strategy, we will only select a few of the entities that seem to have the most direct influence on the awareness of and successful utilization of the program.

XYZ REGIONAL MEDICAL CENTER

Figure 1: Influencers of Telehealth Awareness, Utilization, and Reputation

The target audiences for our marketing efforts consist of the following constituents:

- **Hospital administration and staff** whose help we need to execute the telehealth program (through funding, advocacy, and actually using the telehealth solution for their patients).

- **Referring providers** who we want to participate in the service (by recommending their patients to take advantage of the service). Providers can be staffed at the hospital, be private practice physicians (e.g. primary care) who refer their patients into the RMC, or can also be clinicians at local nursing homes and long term care facilities.

- **Supporting organizations** who we want to use as channels to publicize and advocate the service to their members. These can be local employers, churches and charities that have close relationships with the local population and are more likely to know about their healthcare challenges.

- **Patients** who we want to use the service.

The map also shows us that the local media has strong influence on hospital administration, legislators, supporting organizations, and referring providers. A key element of our marketing strategy will therefore be to leverage the media to help advocate for telehealth with these other key influencers.
MARKET ANALYSIS: PROBLEMS, ALTERNATIVES, TELEHEALTH SOLUTION BENEFITS

Having selected the marketing targets, the next step is to figure out what we want to speak with them about. Before making the mistake of jumping right into a discussion of telehealth, identify their specific challenges and the options they have for addressing these challenges. Then identify the unique benefits that telehealth can bring by resolving the challenges in ways that the other alternatives do not.

Ensure that the analysis is specific to each target market. A generic analysis is likely to fall flat because it does not dive deep enough into the specific issues for any one targeted group.

In this section, we review each of our top target audiences in terms of the challenges they or their constituents face, the available alternatives for addressing these challenges, and the benefits that the telehealth solution brings to the table.

This section is critical because:

- The **Challenges** inform us on what is really troubling our target audience and causing “pain” or stress that they would welcome help in relieving. Alleviating these issues should be the main talking points of the telehealth solution.
- The **Alternatives** tell us what is directly or indirectly competing with the telehealth solution, so that we can figure out our relative strengths and weaknesses.
- The **Benefits** section helps us see what are likely to be the top benefits of our solution in the eyes of our target audience. Many benefits will overlap across different audiences, while others will be more unique. The goal is to identify the benefits associated with resolving the challenges identified earlier.

HOSPITAL ADMINISTRATION & STAFF

**Challenges**

- Attracting specialized healthcare resources needed to serve the community effectively.
- Fiduciary responsibilities to the hospital are incompatible with the cost of providing highly specialized care.
- Patients from the community end up at more sophisticated care facilities because they cannot be served at the RMC.

**Alternatives**

- Continue to provide the same limited level of healthcare services.
- Sacrifice profits and/or other expenses in order to hire more specialists.

**Telehealth Solution Benefits**

- Provide better healthcare services to the community.
- Keep patients at our facility rather than having to transfer them out just to see a provider.
- Retain revenues for providing care to the local community.
- Showing the community that its local hospital has access to leading edge technology and services.
- Effective stewardship of the hospital.
REFERRING PROVIDERS

Challenges
- Patients need the help of specialists that are not in our local community.
- Patient care plans and treatments are delayed because they don’t have the time, resources, or funds to see the specialists whose expertise is needed to diagnose their situation.
- Some patients are lost to other providers or facilities because they have to be referred out.

Alternatives
- Keep patients local with limited access to specialists.
- Send patients to far away facilities – which is suboptimal for their quality of life; in addition, many of them don’t go anyway and their situation deteriorates.

Telehealth Solution Benefits
- Enable their patients to stay local and not get transferred away.
- Enable their patients to see a specialist more quickly (reducing wait time from months to days).
- Get faster diagnosis to create more effective treatment plans for their patients.
- Use technology on the leading edge of healthcare.
- Retain the patient and the associated revenues.

PATIENTS

Challenges
- Lingering healthcare issues for which they cannot get local help.
- Care is delayed because they cannot take the time off to drive hundreds of miles or many hours to see a specialist.
- Care is delayed because the wait time to see the specialist is many months away.
- Don’t want to go far away and leave their support network behind (in case they are required to stay).
- Don’t want to go far away for care and put an undue burden on their support network to take time off of work to be with them, etc.

Alternatives
- Try in vain to find someone local who can help.
- Delay care and live with the problem until their situation deteriorates to the point they need to be admitted or they eventually go to see a specialist who is many hours and/or miles away.

Telehealth Solution Benefits
- Access to clinical specialists that are not in their community, but who can address their issues.
- Eliminate long wait times to see specialists who are far away.
- Avoid the costs of having to drive 2-5 hours to see the specialist (time off from work, time away from family, etc.).
- Taking advantage of technology that is at the leading edge of healthcare.
SUPPORTING ORGANIZATIONS: EMPLOYERS

Challenges
• Employees are suffering from health problems that they cannot resolve, and it is affecting their productivity.
• When employees take time off for sick leave, it disrupts the shift schedule and affects production and increases costs.

Alternatives
• Let employees live with their situation and let the business suffer the consequences.
• Try to find a way (legally) to replace unproductive employees.

Telehealth Solution Benefits
• Employees stay healthier and more productive.
• Employees need less time off for sick leave if they have local access to healthcare.
• Employee attendance becomes more reliable and predictable.

SUPPORTING ORGANIZATIONS: CHURCHES AND CHARITIES

Challenges
• Members share health issues that are negatively impacting home and work life, and there is nothing the organization can do or recommend to help them.

Alternatives
• Provide consolation and resources to help deal with the symptoms, but not the cause.

Telehealth Solution Benefits
• Members stay healthier and have less life challenges when their healthcare issues can be addressed more quickly.

In summary, the telehealth program is well-positioned to provide a wide variety of benefits for our different audiences. The primary alternative which is the status quo does not provide much benefit.
MESSAGE

Bring the elements from the Market Analysis together into guiding messages that can be used in marketing materials. This is where you get closer to “copy” – actual words that will be used in your marketing materials.

How do we want to attract our target? How will we differentiate our offering?

What claims will we make (that we can justify)? Because this solution is in healthcare, be careful that your claims are defendable. In other words, you cannot guarantee patient outcomes, but you can promote the solution as having demonstrated certain outcomes.

To gain the interest of our target audiences, we will use opening messages that ask questions related to the problems they are experiencing.

PATIENTS: “Do you have a healthcare problem that just won’t go away? Are you delaying care because (1) you can’t take the time off to drive 3 hours to see a specialist (2) the wait time to see the specialist is many months away (3) you’re afraid of having to go for care outside our community and end up having to stay? (leaving your family and friends behind or creating another burden on them)”

EMPLOYERS: “Does it seem like your employees are not as healthy as they could be? Is it impacting their productivity or increasing their use of sick leave? Would you like to find a way to help them get the care they need to improve their health, need less time off, and be happier and more productive?”

CHURCHES AND CHARITIES: “Have any of your members spoken with you about health issues that are causing terrible stress on their personal or professional life? Have they delayed treatment because they can’t get help locally and don’t have the time or work flexibility to get the help they need?”

REFERRING PROVIDERS: “Do any of your patients need the help of specialists that are not in our local community? Is their treatment being delayed because they don’t have the time, resources, or funds to get to that care? Are you concerned with losing these patients to other providers or facilities if you refer them elsewhere?”

ADMINISTRATION: “Are you challenged with attracting the healthcare resources needed to serve your community effectively? Does it feel like your fiduciary responsibilities to the hospital are incompatible with the cost of providing highly specialized care? Wouldn’t it be nice to not lose patients to facilities who have more sophisticated care capabilities?”

We will follow up these opening messages with an introduction of our telehealth solution and how it can help. This is where we can talk about the benefits that the telehealth solution can bring to them.

SAMPLE HEADLINES

No matter what the message, we will need attractive headlines to get people to open / read our marketing materials whether these are in the form of emails, brochures, press releases, etc. Below are some ideas for the kinds of headlines we will want to use:

• Your wait time for a neurologist just went down from 9 months to 3 days
• XYZ RMC’s new telehealth program reduces wait time for medical specialists by up to 99%
• “I couldn’t have imagined a better outcome” – a patient’s comeback with the help of telehealth
• Acme Inc. reduces employee sick leave by 25% through cutting edge healthcare
• 5 UC-Davis pediatric specialists make visits to XYZ RMC – over the Internet
RESOURCES

Identify the resources available to support various marketing activities. Resources can be team, financial, etc. Changes in these could affect ability to execute on time, within budget, or in a way that achieves targeted goals.

TEAM

We will leverage the hospital staff as follows:
• IT – Website development
• Marketing – Copywriting (for website, brochures, press releases, etc.), brochure development, organizing Connected Health Media Day, media relations.

FINANCIAL

Our entire marketing budget for the year will be $1,600, excluding the Connected Health Media Day which will be funded separately by Administration after further details are ironed out.

MEDIA

Identify the means by which we will reach our target audiences with our message. Explain why specific activities have been chosen over others.

We have many options for getting the word out about the new program.

We have evaluated the various options according to the following criteria:
• Skills / resources to execute
• Time and effort required
• Potential Impact
• Cost

Our analysis indicates that the top opportunities consist of the following:
• Web site
• eNewsletter
• Brochures
• Press Releases & Articles
• Satisfaction Surveys (from Patients, Clinicians, and Administration)
• Connected Health Media Day
• Social media
• Face-to-face visits

The underlying strategy in all the marketing efforts is to consistently communicate the benefits of the solution, over and over, so that the message drives home. The intent is that at the point that a member of our target audience comes across an opportunity to talk about, use, or recommend telehealth versus another option, they will actually recall (1) that the telehealth option exists and (2) the benefits of the solution. These should be lodged in their mind powerfully enough for them to choose or at least consider the telehealth option.
MARKETING ACTIVITIES

Provide a summary of the key marketing activities. Include information on each activity that could be easily compared across activities. These can include: Description, Objectives Served, Target Audiences, Frequency, Metrics for Success, Resources Involved, and Budget.

Each Marketing activity has been laid out in terms of the following components:

• Activity
• Brief Description
• Objectives served (e.g. Visibility, Utilization, and / or Reputation)
• Target audiences – which audiences will be the beneficiaries of this marketing activity
• Frequency – how often this particular activity will take place
• Metrics for success – how we will measure successful progress on the activity
• Resources involved – which human resources will be involved in the activity
• Budget – both startup costs and operating costs are estimated

The table at right provides a detailed view of these elements for the different activities we have identified.
<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Objectives Served</th>
<th>Target Audience(s)</th>
<th>Frequency</th>
<th>Metrics for Success</th>
<th>Resources Involved</th>
<th>Budget</th>
<th>Startup costs</th>
<th>Ongoing costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website</td>
<td>Include overview of telehealth program, team, providers, technology, and benefits. Also include contact info and sign-up form to receive eNewsletter.</td>
<td>x</td>
<td>Patients, Hospital Administration, Referring Providers, Supporting Organizations</td>
<td>Ongoing updates as needed</td>
<td># of Visitors # Signing up for newsletter</td>
<td>Telehealth Director, IT</td>
<td>$200-$1,000 extended BMC website to include Telehealth Section</td>
<td>$0 (use existing website)</td>
<td></td>
</tr>
<tr>
<td>eNewsletter</td>
<td>Using Constant Contact to send out info on telehealth benefits, technology, consulting physician profiles, and success stories.</td>
<td>x x x</td>
<td>Patients, Hospital Administration, Referring Providers, Supporting Organizations</td>
<td>Monthly</td>
<td># of subscribers Open rate</td>
<td>Telehealth Director, IT</td>
<td>$0</td>
<td>$10-$50 / month</td>
<td></td>
</tr>
<tr>
<td>Brochure – general</td>
<td>Printed brochure or flyer that explains telehealth and its benefits to patients.</td>
<td>x x</td>
<td>Patients, Supporting Organizations</td>
<td>One Time</td>
<td># of people contacting us for more info</td>
<td>Telehealth Director, Marketing</td>
<td>$20-$1,000 depending on # of reprints and quality of material / design</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Brochure – referring providers</td>
<td>Printed brochure or flyer that explains telehealth and its benefits to providers and their patients.</td>
<td>x x</td>
<td>Referring Providers</td>
<td>One Time</td>
<td># of people contacting us for more info</td>
<td>Telehealth Director, Marketing</td>
<td>$20-$500 depending on # of reprints and quality of material / design</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Press Release</td>
<td>Stories that highlight the local healthcare problem and the solution. Use patient stories to convey the message. Press releases will also be posted on the website.</td>
<td>x</td>
<td>Patients, Hospital Administration, Referring Providers, Supporting Organizations</td>
<td>2-3 / year</td>
<td># of people contacting us for more info</td>
<td>Telehealth Director, Marketing</td>
<td>$20-$750 / release depending on length and outlet used</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Satisfaction Survey – Patient</td>
<td>How would you rate the experience (1-10)? Would you recommend it to a family member or friend (1-10)? What can we do to improve it?</td>
<td>x x</td>
<td>Patients, Hospital Administration, Referring Providers, Supporting Organizations</td>
<td>Per encounter</td>
<td>Satisfaction score</td>
<td>Telehealth Director</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Satisfaction Survey – Clinician</td>
<td>How would you rate the experience (1-10)? Would you recommend it to a colleague (1-10)? What can we do to improve it?</td>
<td>x x</td>
<td>Hospital Administration, Referring Providers</td>
<td>Every 6 months</td>
<td>Satisfaction score % that would use it again</td>
<td>Telehealth Director</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Satisfaction Survey – Administration</td>
<td>How would you rate the success of the telehealth program (1-10)? What benefits do you see?</td>
<td>x x</td>
<td>Hospital Administration</td>
<td>Annual</td>
<td>Satisfaction score % that can identify telehealth benefits</td>
<td>Telehealth Director, Administration, Marketing</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Connected Health Media day</td>
<td>Event designed around showcasing and demonstrating the new solution. Will include administrators. Will also have specialists from UC-Davis on by video-conference to talk about what they do during a consult.</td>
<td>x x x</td>
<td>Patients, Hospital Administration, Referring Providers</td>
<td>Annual</td>
<td># of Attendees # Signing up for newsletter</td>
<td>Telehealth Director, Administration, Marketing</td>
<td>TBD</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Guest article in local paper</td>
<td>Stories that highlight the local healthcare problem and the solution. Use patient stories to convey the message. Guest articles will also be posted to the web site.</td>
<td>x x x</td>
<td>Patients, Hospital Administration, Referring Providers, Supporting Organizations</td>
<td>2-3 / year</td>
<td># signing up for newsletter</td>
<td>Telehealth Director, Marketing</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Social media</td>
<td>Videos on YouTube profiling consulting physicians, participating clinicians, benefitted patients, and technology in use. Links embedded in web site.</td>
<td>x</td>
<td>Patients, Supporting Organizations, Referring Providers</td>
<td>At least1 / quarter</td>
<td># signing up for newsletter # of Views</td>
<td>Telehealth Director, Marketing</td>
<td>$0 (possible video production costs)</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Face-to-face visits</td>
<td>In-person visits with referring providers, supporting organizations, and administrators to talk about the problems that the telehealth solution will address and to alleviate questions and concerns</td>
<td>x x x</td>
<td>Hospital Administration, Referring Providers, Supporting Organizations</td>
<td>As many as possible</td>
<td># of people contacting us for more info</td>
<td>Telehealth Director</td>
<td>$0</td>
<td>Minimal local travel expenses</td>
<td></td>
</tr>
<tr>
<td>Conference attendance</td>
<td>The regional rural health association’s annual conference in July will be a good place to network and pick up best practices. We will also attend the CTN annual conference in April.</td>
<td>x x</td>
<td>Supporting Organizations</td>
<td>Annual</td>
<td></td>
<td>Telehealth Director</td>
<td>$750/conference</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>
MARKETING ACTIVITY DETAILS

For specific marketing activities that require more details, provide them in this section. For example, for a website, include more info about the content that it could include. The previous section provided a brief description of the key marketing activities. In this section, we look at some of the key activities in more detail.

WEBSITE

The web site is intended to be useful to all of our target audiences – patients, providers, internal administration and staff, and supporting organizations.

The site will be a one-stop resource for information about:

- The clinical services offered
- Profiles of the physicians (and other clinical specialists) who will be providing telehealth services
- Stories of how telehealth has changed people’s lives
- Telehealth technology (as demonstrated by YouTube videos embedded on the website)
- Telehealth benefits (broken out by different constituents)
- How to get started
- Articles that highlight demonstrated proof that telehealth works both clinically and economically
- Links to resources for info on telehealth (e.g. CTRC, CTN, American Telemedicine Association)
- The telehealth team
- Contact info

The site will also include a sign-up form for people to receive our telehealth newsletter.

The intent of the website is to:

- Make patients more comfortable with using the service
- Make referring providers more comfortable with recommending that their patients take advantage of the service
- Make supporting organizations more comfortable with recommending the service
- Help administrators better understand the program so that they support the telehealth program through continued/increased funding and general advocacy
- Help internal staff better understand the program so that they support the telehealth program through continued participation and advocacy
- Get website visitors to sign up for the newsletter

While this is a lot of content to develop, it will serve multiple purposes. Portions of the content can be re-used for other media as well – for brochures, flyers, presentations, videos, etc.

NEWSLETTER

The newsletter will provide a continuous drip of the content that is already available through the website. This way, people don’t have to remember to visit the website to get more info. The newsletter will also provide new information as it develops. For example, new clinical disciplines being added to the program, or patient success stories.

The benefit of the newsletter is that it maintains continuous communication with subscribers. As a result, the telehealth program will be front and center when it comes time for a subscriber to consider a healthcare situation where telehealth could be of use.
BROCHURE
The brochure will serve as a leave behind for supporting organizations to remind them of the telehealth program. Because of budget limitations, this will likely be in the simple form of a 1-page 4-color flyer, front-and-back. It will contain essential info about clinical specialties covered, benefits, success stories, a few testimonials, and how to get access to the program.

PRESS RELEASES / GUEST ARTICLES IN NEWSPAPERS
The goal of the press release and guest articles is to raise broad awareness for the program and to develop a strong relationship with the media. Ultimately, we would like to use the print-based outreach as an avenue to get exposure through our local TV and radio stations.

CONNECTED HEALTH MEDIA DAY
This 3-hour “open house” is designed to introduce telehealth to the community by way of a big event. It will involve press releases and other media announcements leading up to the event. We will try to have 2 or more of the consulting physicians available through the telehealth video-conferencing system to talk about how they do consults and share some success stories. We will encourage the public to stop by and see a demonstration of the new technology – and to virtually meet some of the physicians.

Attendees will also be provided an opportunity to sign up for the newsletter or pick up a brochure.

Additional goals for the event:
• Get business sponsors to provide food and drinks (which always bring in people)
• Have legislators from the city, county, and region in attendance.

SATISFACTION SURVEY
Satisfaction surveys will be our primary means of getting direct systematic feedback on the success of our program. This needs to be holistic in that we will solicit feedback not just from patients (as is typical), but also from clinicians that participate in the program, and even from administration.

Survey results will be used for both external marketing efforts (info on website or in press releases) and internal marketing efforts (presentations to administration and staff).

SOCIAL MEDIA
Our initial target for social media is YouTube. It is a popular multi-media site where we can create our own channel for free. We can also embed videos from our YouTube channel into our own website – thereby, getting more leverage out of the work already done to create the videos. Ideas for videos include:
• Patient success stories
• A demo of how the telehealth technology works
• Testimonials from staff who have used the technology
• Interviews with physicians who provide telehealth consults

FACE-TO-FACE VISITS
Face-to-face visits are critical for educating and creating comfort for telehealth with supporting organizations like local churches, the local HIV/AIDS support center (for Infectious Disease consults), EMS, local mental health counselors, and the region’s top employers.

We will sit down with them to talk about the challenges in their environment and identify ways that telehealth could help them out. We will provide brochures as a leave behind.
SUCCESS METRICS

Marketing activities should produce measurable results. This is the section for describing how each marketing activity will be rated in terms of success. While the Marketing Activities Summary will identify success metrics each individual activity, this section will aggregate all success metrics across these activities (as some metrics will be served by multiple activities). In addition, identify the targeted value of these metrics and the various activities that contribute to each metric.

Below are our success metrics and targets:

<table>
<thead>
<tr>
<th>METRIC</th>
<th>TARGET (1st year)</th>
<th>ACHIEVED THROUGH</th>
</tr>
</thead>
<tbody>
<tr>
<td># Website visitors</td>
<td>1,000</td>
<td>Google Analytics installed on website, Calls to Action that drive people to the website.</td>
</tr>
<tr>
<td># Sign-ups for newsletter</td>
<td>250</td>
<td>Website, newsletter shares, brochures, social media</td>
</tr>
<tr>
<td>Open rate</td>
<td>25%</td>
<td>Newsletter content</td>
</tr>
<tr>
<td># People contacting us for more info</td>
<td>50</td>
<td>Website, Brochures, Press releases, face-to-face visits</td>
</tr>
<tr>
<td>Satisfaction score: Patients</td>
<td>90%</td>
<td>Survey</td>
</tr>
<tr>
<td>Satisfaction score: Clinicians</td>
<td>80%</td>
<td>Survey</td>
</tr>
<tr>
<td>% of clinicians that would use telehealth again</td>
<td>90%</td>
<td>Survey</td>
</tr>
<tr>
<td>Satisfaction score: Administration</td>
<td>80%</td>
<td>Survey</td>
</tr>
<tr>
<td>% of Administrators that can identify at least 3 telehealth benefits</td>
<td>75%</td>
<td>Survey</td>
</tr>
<tr>
<td># Views in Social Media</td>
<td>300</td>
<td>YouTube metrics</td>
</tr>
</tbody>
</table>

MARKETING PLAN SAMPLE: XYZ Regional Medical Center
Summarize the financial outlay for the marketing plan. Break it out in different ways if possible – by month, by activity, by capital costs vs. operating costs.

The total budget for this plan is $1,550.

Below are the projected monthly marketing expenses for the program:

Monthly Expenses

This marketing plan was prepared by Nirav Desai, Founder and CEO of Hands On Telehealth, on behalf of the California Telehealth Resource Center.
tab 5 goes before page 124
Planning

What kinds of telehealth equipment choices are available?

Telehealth equipment and telemedicine systems are available for various telehealth applications and come in many sizes, such as mobile laptop-based units, desktop models, units in movable carts, wall mounted units and unit for the home. Live interactive telemedicine uses a camera, monitor, speakers, microphone and CODEC, for real time two way audio and video. Store and forward telemedicine uses software specifically designed for the secure transmittal of digital information to a provider. Store and forward may use digital cameras to capture images, electronic stethoscopes or other devices to capture sounds. Home telehealth employs equipment to capture images, electronic stethoscopes or other devices to capture sounds. Home monitoring devices often include blood pressure meters, pulse oximeters, scales, blood glucose monitors and others.

While this toolbox focuses primarily on clinical use, it should be noted that distance learning equipment uses the same equipment as that used for live interactive, although usually configured with larger monitors and additional input sources for connecting additional cameras and computers.

How do I go about identifying equipment requirements that meet my program’s need?

Equipment should be selected to work with the type of telemedicine application you are implementing. Before equipment is selected, a needs assessment is usually undertaken to determine the clinical need for telehealth services and decisions are made about the services the organization plans to provide or receive. This information will determine the type of telehealth application and the type of equipment that is suitable to that application. You want to make sure that the hardware and software will meet the requirements of your selected service and will meet any technology requirements of your organizations. This is also the time to consider the flexibility and interoperability of the equipment. Each component of the telehealth equipment has operating specifications and features. Monitors, microphones, cameras and CODECs each have different models with different capabilities. The specifications for each component need to match your program’s requirements.

With input from clinical staff, create a list of the technical specifications and features that are required for your program and a list of those specifications and features that are desirable. This exercise will ensure that the program’s needs are met and at the same time allows the eventual users of the telehealth technology to feel they are involved and invested in the decision making process. Your intended use of the equipment will drive the equipment requirements. For example, medical specialty services in a small remote clinic exam room may require a small monitor while a distance education
program in a conference room would optimally have a large monitor. Look at the product lines of different manufacturers to determine which models meet your requirements. It would be very wise to discuss specific hardware and software requirements with the specialists you intend to call upon for telehealth services before purchasing anything. If you are new to telehealth equipment and technical specifications it can be worthwhile to seek the advice of an expert when creating or reviewing equipment requirements to ensure that the needs of the telemedicine program will be met. It is advisable that your team dedicate focused time and effort on evaluating different product lines prior to moving on to the vendor selection.

Regional Telehealth Resource Centers or another experienced telehealth program staff can assist you in determining what equipment would be used for the desired telehealth services and what technical specifications are necessary for that service.

When should I select and purchase equipment?

The equipment selected for your telehealth program needs to be appropriate for the clinical or program need and the environment in which it is to be used. Therefore, equipment selection should be done only after a needs assessment and market analysis have been completed to determine what services the facility hopes to provide or receive. Different telehealth applications have different modes of services and different equipment requirements. For example, dermatology services can be provided in a live interactive setting or with a store and forward approach. Each approach has different equipment requirements. Selecting equipment too early in the process can result in inappropriate equipment that may lead to wasted money or leave your program in a situation where it cannot provide the intended services.

Connectivity needs and availability should also be assessed prior to making any purchase decisions for telehealth equipment. If, for example, you will be connecting via ISDN, you may need to purchase additional equipment for this type of connectivity. Other factors to consider are placement of the equipment, electrical requirements and availability of network cabling at the installation location.

How do I select a vendor?

A new telehealth program may require vendors for telecommunications, equipment, and support. Most telehealth equipment manufacturers do not sell directly to healthcare organizations. The manufacturers work with partners and resellers, that often offer value added services to their customers, such as installation, training and support services. A list of resellers can be found on each manufacturer’s website. Resellers are usually ranked by the manufacturer in tiers based on the level of services they provide and amount of business they do with the vendor. Resellers in higher tiers will most likely receive more favorable pricing based on the volume of their purchases and may be required to receive additional training for their staff in order to maintain their status. This can translate into a better pricing and support for their customers.

Criteria for selecting a vendor includes: type of equipment required, availability of desired equipment, price of equipment, delivery schedule, cost for installation, training, support services, maintenance agreements, and response time requirements. The vendor may be able to provide discounts for bundling multiple pieces of equipment and for volume purchases. The vendor’s references should be contacted to discuss the vendor’s performance and support response times.

A Request for Proposal (RFP) or Request for Information (RFI) can be developed, outlining the telehealth program you want to develop and the equipment you believe is needed. Creating and distributing an
RFP and then analyzing the results can lead to conversations with vendors that may lead to changing your mind about what equipment you need. If you do consider changing your hardware, software, or services requirements as a result of a vendor contact, be sure to validate that change with an objective party (e.g. your Telehealth Resource Center, a trusted and experienced telehealth advisor from a peer organization).

**What are videoconference standards and is all telehealth equipment interoperable?**

There are many standards that are utilized by videoconference equipment manufacturers in their equipment and software. Standards are used for video compression, audio compression, connectivity, encryption and other aspects of the equipment. The standards are defined by the Telecommunication Standardization Sector (ITU-T) on behalf of the International Telecommunication Union (ITU). Videoconference systems that use the same standards will almost certainly be interoperable with each other, allowing successful videoconferencing between units of different manufacturers. Some videoconference manufacturers use protocols that are proprietary, meaning their equipment does not use open standards for communicating voice or data. This equipment is most likely not interoperable with standards-based equipment. When selecting equipment, it is important to ask for specifics on interoperability between different manufacturers equipment and to determine the impact of selecting a standards-based or proprietary system.

The two main standards used in videoconferencing today are H.320 for ISDN based networks and H.323 for packet switched or IP networks. Within these two umbrella standards are contained additional standards that control the many aspects of a videoconference session.

A relatively new standard has been developed by the Internet Engineering Task Force (IETF) Network Working Group. The Session Initiation Protocol (SIP) enables users to seamlessly communicate via instant messaging, phone, e-mail, voicemail and videoconference technologies and is widely used for controlling audio, video and multimedia communications.

**Is telehealth equipment HIPAA compliant?**

Patient and provider sites are required to adhere to Health Insurance Portability and Accountability Act (HIPAA) regulations when providing services by telehealth. HIPAA regulations require an entity to determine the risk associated with a particular service or technology and to implement procedures to mitigate that risk. Most telehealth equipment is HIPAA compliant. This is achieved through the use of data encryption, which secures the data from unauthorized users and allows only an authorized user to decode and view the data transmitted. When a CODEC establishes a connection with the encryption option enabled, the connection between the two units will be secured using a common encryption algorithm, such as the Data Encryption Standard (DES), Triple DES (3DES) or the Advanced Encryption Standard (AES). Proper safeguards should be taken to secure Protected Health Information (PHI), including that transmitted through telehealth.

It is important to note that the videoconference equipment is not the only area of the telehealth program that requires HIPAA compliance. For example, documents transmitted from the patient site to the provider sites (paper and electronic) must be protected from unauthorized access and facilities at both the patient and provider sites must ensure that the telemedicine consultation takes place in a quiet and confidential setting.
How much should I budget for the purchase of equipment?

Telehealth equipment costs can vary substantially depending on the size of the unit, configuration, features selected and specialized equipment (e.g. telemedicine ready otoscope, dermascope, etc.) required. These decisions will depend of the type of telehealth service that is going to be implemented. When budgeting for equipment, it is important to understand all of the costs that will be incurred both initially and on an ongoing basis. Some of the options you will need to consider include dual monitor support, multipoint capabilities (i.e. the ability to have more than two sites simultaneously connected to the video session), additional cameras, and high definition.

Costs vary. Desktop based units are priced around $4,000, high definition units for midsized conference rooms are priced around $20,000, pole mounted clinical exam units are priced around $10,000 mobile battery powered clinical carts are priced around $40,000 and remotely controlled telemedicine systems can cost upwards of $250,000. Many vendors offer leasing options for their equipment so that payments can be spread out over time or so that the equipment can be traded in when the lease expires. The need for specialized scopes (ie, stethoscopes, otoscopes) and general use cameras will increase the procurement cost for patient sites wishing to do specialty services. Provider sites typically do not need diagnostic equipment, although some devices occasionally require a peripheral for receiving and reviewing data from the originating site.

Initial costs also include installation and configuration of the equipment, training for staff and any consultation costs associated with evaluating and selecting equipment. Ongoing budgets need to include funding for support and maintenance. Support and maintenance agreements are usually available from the equipment vendor, usually in one, two or three year terms. The support and maintenance agreements cover technical support from the vendor for equipment issues, repair or replacement if the equipment fails and periodic software and firmware upgrades. Support and maintenance agreements are usually based on a percentage (15-20%) per year of the equipment costs. Programs should also budget for ongoing IT support and for additional training that may be required due to staff turnover or program expansion.

How much should I budget for connectivity?

Connectivity charges are recurring monthly costs that will vary depending on the amount of bandwidth you are purchasing, your location, and the competition by service providers. In some cases, as with ISDN, in addition to Monthly Recurring Charges (MRC) for the circuit, there are also per minute usage charges. When purchasing telecommunication circuits, there are usually discounts if you agree to a two or three year term. For many circuits there is also a onetime Non-Recurring Charge (NRC) for installation. This fee is usually waived by the telecommunications provider if you agree to a multiyear term. Circuit costs can range from $30/month for DSL circuits to $500/month for a T1 1.5Mbps MPLS circuit to $5,000/month for a DS3 45Mbps circuits. The cost for circuits in rural areas, where bandwidth may be very limited and advanced telecommunications may be non-existent can be significantly higher. Many states are implementing FCC funded broadband expansion projects with discounts for rural healthcare providers. These programs are designed to improve access to healthcare by expanding access to affordable broadband services.

In addition to the costs for the telecommunications circuits, other hardware may be needed to establish connectivity for your telehealth program. A router, firewall, and/or VPN appliance may be needed to establish connectivity or to secure the connection to the remote site. In some cases, telecommunications providers can bundle the cost of the additional hardware and provide management of the circuit and hardware. This may be preferable in cases where in-house expertise is not available to configure and maintain the telecommunications equipment or where there is no budget for such equipment.
What discounts are available for telecommunications?

The Federal Communications Commission (FCC), through the Universal Service Program, offers subsidies on telecommunications circuits. Funded by the Universal Service Fee and administered by the Universal Service Administrative Company (USAC), the program aims to increase access to telecommunications and advanced services in schools, libraries and rural health care facilities. For eligible regions, costs for circuits under this program are subsidized to the cost of equivalent service in urban areas. This program allows rural health care facilities to receive subsidies on telecommunication that provide relief from the disparity between urban and rural rates. For more information on USAC, visit www.usac.org.

In 2007, the FCC created the Rural Health Care Pilot Program (RHCPP), which funded many collaborative groups, telemedicine networks, hospitals, health information exchange organizations and others for the construction of 69 statewide or regional broadband telehealth networks in 42 states and three U.S. territories. Using the $417 million in dedicated funds, these groups are making broadband available to many health care facilities at reasonable rates. For more information on the Rural Health Care Pilot Program, visit www.usac.org/rhc-pilot-program/.

In addition to these programs, some states have developed their own telecommunication discount programs. For example, the State of California’s California Teleconnect Fund (CTF) program managed by the Public Utilities Commission, offers a 50% discount on covered services for eligible entities. To determine if a program such as this exists in your state, contact your state’s Public Utilities Commission or your regional Telehealth Resource Center. You can find a listing of telehealth resource centers at www.telehealthresourcecenter.org.

Can I use telehealth from home or while on the road?

Yes, telehealth can be used from home or while on the road. As with any telehealth equipment, sufficient bandwidth should be available at the location to ensure that video and audio quality do not degrade during the session. It is also important to remember that if, during the telehealth connection, patient information will be discussed, the connection should be encrypted to secure the connection and that other safeguards should be taken to protect patient’s privacy. For example, telehealth sessions should only be conducted in private areas in which conversations cannot be overhead.

Videoconference manufacturers understand the need to have mobile connectivity to their videoconference systems. Several vendors offer software-based videoconference systems that can be installed on laptops or desktop computers. Many laptops now offer built in webcams, microphones, speakers and mobile broadband connections, making these ideal for providers who must have the ability to connect from anywhere at any time. Patients may also use telehealth equipment in the home. Video based home units can allow for services such as wound care and behavioral health from the home. Home monitoring units allow patients to transmit vital signs and some diagnostic data to allow for regular monitoring.

When considering mobile applications the same needs for security, picture and audio quality, and confidentiality apply.
Equipment

What kind of equipment is used for live interactive telemedicine?

In order to participate in a live interactive telemedicine session, equipment capable of sending and receiving audio and video is needed. The basic components needed for sending and receiving audio and video are: a microphone to capture audio, a speaker to hear transmitted audio, a camera to capture video, a screen to view the transmitted video, and a CODEC to compress the signal and transmit it over a network. The CODEC is the heart of the videoconferencing system. CODEC stands for coding/decoding and can be either hardware or software based. All of the inputs and outputs for all the devices are incorporated into the CODEC.

The equipment described above can be configured in many different ways to meet your needs. Software-based CODECs can be installed on laptop or desktop computers for use while traveling or from home. Compact desktop videoconference units are ideal for providers’ desks, as these units incorporate the CODEC, camera, monitor, microphone and speakers into a single device. Equipment can also be wall mounted in an exam room to minimize the footprint of the equipment in space-constrained areas. Telemedicine carts or poles are popular in clinical settings because of their mobility. Some offer wireless connectivity and built in battery supplied power.

Advanced telemedicine solutions are being used in Operating Rooms and Intensive Care Units where telemedicine devices can interface with patient monitors and EHRs. Using this equipment, remote physicians, surgeons, and Critical Care Intensivists have access to diagnostic data provided by the patient monitoring systems and the remote physician can direct patient care.

What are some considerations when looking at features of live interactive telehealth equipment? Some important features include:

- Standards-based operating systems
- Transmission speeds of at least 384 Kbps
- Full duplex audio
- Picture in picture capability
- Pan/tilt/zoom functionality for patient sites
- Remote site camera control (primarily to allow the remote provider site to control camera at the patient site)
- Standard ports for peripheral equipment and data transmission
- Storage and workspaces for peripheral equipment
- Ease of use
- Software-based upgrades

What kind of equipment is used for store and forward telemedicine?

Store and forward telemedicine, unlike live interactive, is not viewed by the examining provider in real time. Store and forward telehealth consists of recording an image, audio, or video and transmitting it to a specialist for review at a later time. Because a live interactive connection is not required, the equipment needed for store and forward telemedicine is not as complex. Store and forward provides some workflow flexibility at both the patient and provider sites. Patient sites can collect patient images or data and transmit it to a provider at a later time. Providers have the flexibility of reviewing the images at convenient times. Images for dermatology are typically captured using a digital camera capable of taking close up pictures (macro mode). Digital cameras are also used for digital retinopathy screenings.
Handheld cameras are used for retinopathy screens as well as highly specialized units that include head placement frames. Electronic stethoscopes can capture heart and lung sounds and transmit those sounds as electronic files or signals to remote cardiologists or pulmonologists for diagnosis.

Capturing the image, audio, or video is only part of the equation for store and forward telemedicine. The store and forward applications require equipment or software to securely transmit the image, audio, or video. The secure transmission of the recorded information can be accomplished in several different ways. One way is to use third party e-mail encryption software to secure the information being sent to and from the specialists. There are software programs that can do this automatically and are specifically designed for use with store and forward telemedicine. Another option is to upload the image to a secure Picture Archiving and Communication System (PACS). Consultation reports are then transmitted from the specialist to the primary care provider through fax or electronically through an encrypted connection.

In-Home and chronic disease telehealth monitoring equipment also falls within the general definition of Store and Forward telehealth. Devices at the home of the patient are setup to capture vitals and other diagnostic information which can be transmitted to a provider for analysis and review. Using the information captured in the home, a treatment plan can be assessed and modified for the patient with near real time determination of the impact the plan is having on the patient.

What kind of equipment is used for distance learning?

Distance learning equipment follows along the same lines as equipment used for live interactive telemedicine. The equipment is adapted for use in conference rooms by adding multiple monitors, additional microphones and more speakers, depending on the size of the room. Most videoconference equipment also allows the user to connect a laptop and/or DVD player for transmitting a PowerPoint presentation or instructional material through the videoconference. There are also additional network components that are available for recording distance learning events for playback at a future time. Most distance learning events are coordinated events where multiple sites connect to a single presenter site through a Multipoint Control Unit (MCU), otherwise known as a bridge.

What are peripherals and what peripherals can I use with my equipment?

Most videoconference hardware has the ability to connect additional diagnostic tools, referred to as peripherals, using additional input sources on the CODEC. These peripherals include commonly used diagnostic equipment such as otoscopes and hand held cameras that allow the provider at the remote site to further assess the patient with the assistance of a patient presenter. These devices can be used to capture vital signs, listen to heart and lung sounds, examine the eyes, ears, nose, and throat, and much more. The most commonly used peripherals include the general examination camera, vital sign monitor, stethoscope and otoscope. These peripherals are plugged into the auxiliary input sources and by switching to that input during a telemedicine encounter, the provider is able to have a more thorough examination of the patient.

How can I engage my local IT staff in evaluating and selecting equipment?

Your local IT staff or a qualified consultant should be engaged to determine that network requirements can be met for any telehealth equipment that will be installed. This would include determining if appropriate network cabling exists in the areas where the telehealth equipment is to be installed and that adequate bandwidth is available to accommodate the heavy demand placed on the local area network and Internet connection or wide area network by live interactive telemedicine. If any upgrades need to be done in preparation for the telehealth equipment, it is best to have that done prior to ordering equipment so that equipment is not stored for a long period of time while awaiting installation. Some states and accreditation programs require that wall mounted equipment be inspected or meet certain criteria, such as extra wall reinforcement. Because of this, it is advisable to involve plant or facility management staff when determining placement of any equipment that will be fixed.
Should I select standard definition or high definition?

High Definition (HD) videoconferencing equipment is capable of better quality video and audio than are standard definition videoconference units. Most new monitors are designed for HD connections and are best matched up with high definition outputs such as HDMI or Component. In order establish a HD connection, additional bandwidth will be needed, however, HD equipment is capable of connecting at standard rates at the lower bandwidth settings. Considering that HD is commonplace, while standard definition is quickly becoming legacy technology, and that the cost of HD technology continues to decrease while offering much higher quality video and audio, high definition would seem to be the better option for the long term usage within a telemedicine program. In addition, HD equipment uses the same protocols as standard definition equipment, making high definition technology compatible with any standard definition equipment that may still be in operation.

Should I have a fixed or mobile configuration?

When determining whether to have a fixed wall mounted telehealth installation or a mobile cart or pole mounted solution it is important to determine how and where the equipment will be used. A mobile solution works well in areas where equipment is moved from room to room. If a mobile cart is preferred, determine where the equipment will be stored, charged and how it will connect to the network. It is also advisable to check the facility layout to determine if the cart can be safely transported to the different areas where it will be needed. Pole mounted telehealth solutions are self contained and have a small footprint and have been found to be advantageous for many patient site settings. Some patient sites identify one room for telemedicine in order to avoid regular moving of the equipment. If patients presenting for telemedicine encounters will be directed to a determined location or if several areas will be designated for telehealth, a fixed wall mounted installations allow for a sleek, professional look with a minimal footprint and are advantageous when the unit does not require mobility. Wall mounted installations are typically found in conference rooms and classrooms.

Can I just attach a webcam to my laptop and start telehealth services?

While it is possible to use a laptop with a webcam to establish a video and audio connection, careful planning is necessary to ensure that the equipment is appropriate for the situation and that the equipment operates properly and with appropriate safeguards. It is important to ensure that sufficient bandwidth is available from the location where the laptop is connecting. Privacy and security are also very important. Ensuring that proper encryption of the connection is established is also required when connecting from a laptop. If the laptop will be used in public places, it is advisable to get headphones and a privacy screen filter to ensure the privacy of Protected Health Information (PHI). It is also important to note that built-in laptop webcams may present a lower picture quality to the recipient of the laptop transmission. The camera on either end of the connection is always a key factor when it comes to the maximum possible picture quality. A webcam external to the laptop will usually be a better choice for applications requiring higher video quality. Have your videoconference or IT expert evaluate the laptop camera specifications before purchasing either the laptop or an external webcam.

What is a bridge and is it required for telemedicine?

A Multipoint Control Unit (MCU), also known as a bridge, is a network device that allows for conferencing together multiple videoconference connections. MCU’s can also function as gateways, allowing incompatible endpoints (IP and ISDN) to connect to each other. Bridges allow people from many locations to come together in a live interactive format where multiple sites can see and hear each other in real time.
Bridges handle the display of all the participants in different ways depending on the number of participants and the option selected. Bridges can show all parties in small squares on the screen or can show only the person currently talking. Many telehealth units now include bridge functionality for a small number of sites. When the capacity of a single bridge is not enough for a particular event, MCU's can be connected to provide the capacity to allow more participants to join the videoconference.

In a typical telemedicine scenario, known as a point to point connection, where a patient is connecting with a specialist, there is no need for a bridge, unless a gateway is required. Large capacity MCU’s are often used for telehealth events and distance learning such as grand rounds or continuing medical education (CME) trainings. Bridges are also used in multisite environments for peer group meetings, administrative meetings and trainings.

How do I obtain bridging capacity?

You can purchase a bridge or purchase bridge time from a bridging service. Many telehealth units now come with the ability to bridge a few sites together. If this is sufficient for your application, a separate bridge will not be necessary. If your application requires regular multipoint site connections, a thorough analysis of the cost to purchase a bridge should be undertaken. The bridge could be the single most expensive piece of equipment you purchase. The cost of a bridge is typically priced based on port count. The port count (the number of audio, video and telecommunications ports) will determine how many simultaneous connections can be handled by the bridge. If the use of a bridge is only an occasional need, many videoconference vendors, telecommunication companies and other organizations offer bridging services on demand and as needed. These services manage the calls and provide technical support during the call including assistance with audio and video problems and site connection problems.

Connectivity

What kinds of telecommunications connections are available?

Over the years, many different telecommunication technologies have been used for telemedicine. These include ISDN BRI, ISDN PRI, T1 and Frame Relay. In more recent times, the telecommunications industry has developed new technologies specifically for use with videoconference and Voice over IP (VoIP). Multiprotocol Label Switching (MPLS) circuits, one of these new technologies, provide better quality connections through the use of data packet prioritization and Quality of Service (QoS). In addition to these technologies, many telehealth programs are connecting using the public internet through broadband connections such as DSL, Cable or Wireless, and in some cases utilizing a Virtual Private Network (VPN). In some areas, high speed fiber optic circuits or MetroEthernet connections are used to provide connectivity for the facility. Regular telephone service is still used in some areas for telehealth live interactive clinical visits by bonding together many phone lines to create a line large enough to handle the bandwidth of videoconferencing. This is called Integrated Services Digital Network (ISDN). In some very remote areas where little or no telecommunications infrastructure exists or for mobile disaster response vehicles, microwave or satellite connections have been adapted for use with telemedicine.
How do I determine what telecommunications I need?

After analyzing how much bandwidth is needed for your telehealth program, a search for telecommunication providers with service in your area and a review of their service offerings will provide you with a good starting point for determining which telecommunications service will best meet your needs. You would want to determine if a dedicated circuit is preferred or if you can get by with sharing the connection with other networked devices. This can be determined by analyzing how much bandwidth is currently available for all of your computers and whether sufficient bandwidth is available for a telehealth connection. Other factors that should be considered include who you expect to connect with, what type of connection they are using and whether your organization is planning any other health IT projects that will require increased bandwidth. The safest approach is to coordinate your analysis with your IT and telecommunications support providers.

Some telecommunication services do not communicate with each other without requiring additional hardware to translate the signals. Items that should be reviewed when selecting a telecommunication service include, how much bandwidth is included (upstream and downstream), latency, jitter and quality of service. Also important is to determine what type of support or service level agreement the telecommunications provider offers for the circuit, since this will determine how a vendor will respond if an issue occurs.

How much bandwidth is required for telemedicine?

Live interactive telemedicine requires continuous bandwidth. A connection speed of 384 Kbps is common in many telemedicine programs for clinic and hospital based programs. At these connection speeds, a standard quality connection would be established, similar to broadcast television at 30 frames per second. In order to achieve High Definition (HD), at least 1 Mbps of bandwidth is required. A certain amount of bandwidth is needed on each connection to transmit packet identifier information. This additional bandwidth is referred to as overhead. This overhead bandwidth takes away from the bandwidth available for the video and audio. This extra bandwidth requirement should also be considered when determining how much bandwidth is needed.

Store and forward telemedicine is not as bandwidth intensive. A set amount of information needs to be either transmitted or received. After the package has been transferred, the bandwidth is no longer needed. The amount of available bandwidth will dictate how long it takes to transfer the information. In-Home telehealth monitoring equipment needs only minimal bandwidth. The equipment is usually connected to a phone line which dials out at regular intervals or during the night to transmit the data collected during the day.

What happens when I don’t have enough bandwidth?

Not having sufficient bandwidth will result in loss of quality of the videoconference connection. The first thing that will degrade is the video. Video will appear jerky, pixilated, or may even freeze up for some moments. If even less bandwidth becomes available, the audio can also become garbled and there will be a loss of synchronization between the video and the audio. If the connection degrades enough, the signal can be lost all together, causing the telemedicine connection to be terminated. Acquiring connectivity that includes Quality of Service (QoS) levels from the telecommunications carrier will make it possible to allocate the necessary bandwidth for a quality video and audio transmission.
What is Quality of Service?

Quality of Service (QoS) is a feature of network equipment that can tag packets of information while they travel through the network to ensure that they are given priority over other kinds of traffic. For example, videoconference data can be tagged by the telemedicine equipment, giving it a higher priority than web browsing traffic. In the event a decision needs to be made about which packet goes first, the telemedicine traffic would be high priority. Another feature of QoS is that packets are received in the same order in which they were transmitted, which improves video and audio quality. When information is received in sequence, it requires less processing power to reassemble the packets. QoS also allow for reserving blocks of bandwidth for a particular purpose, such as videoconference. This can ensure that bandwidth is available when it is needed and that a successful connection will take place.

Can I use my personal internet connection for telemedicine?

While it is possible to establish a videoconference connection over a public internet connection, this solution should be approached with caution. The internet can become bottlenecked requiring your data packets to be rerouted, adding delay to the time it will take for your data to reach its destination. The internet does not have Quality of Service, which means that there is no guarantee that the packets will be delivered, in what order, or that they will be prioritized over any other kind of traffic. Packet loss can also occur over the internet, which can degrade the quality of the connection. Additionally, information transmitted over the public internet should be secured using either a virtual private network or enabling encryption on the connection.

Can I send store and forward images over the public internet using an email account from my organization or my home?

No. Store and forward images are considered Protected Health Information if they contain identifying information about a patient. Even if the image does not contain any identifying information, it is not advisable to send medical images over the public internet. Personal e-mail accounts typically are not encryption enabled, which means that the e-mail could be intercepted and viewed by someone other than the intended recipient. Likewise, not all organizations have e-mail encryption on their corporate e-mail systems. Your system administrator can determine if your organization’s policies allow for sending of medical information through e-mail.

Operational

What will I need to setup telehealth equipment?

There are two aspects to the setup of telehealth equipment, physical and technical. The location where equipment will be installed will require electrical power and a network connection. When equipment arrives from the vendor, it is important to verify that all equipment that was ordered has been received and a careful inspection should be made to confirm that no parts were damaged during shipping. It is advisable to document for future reference serial numbers and purchase dates of equipment. If support is needed on any piece of equipment, the vendor will ask for the serial number of the device in order to confirm that the device is covered under warranty.
Once the physical setup has been completed, we can move onto the technical setup. The technical setup of the videoconference equipment should be completed by either IT staff or a qualified consultant. Vendors also offer installation services, but they will require specific technical information from the customer. At this stage of the installation, the emphasis is placed on the configuration of the network to pass information to and from the equipment and is normally handled by technical experts. Information required for the setup of the telehealth equipment includes IP address, subnet mask, default gateway, DNS servers and device name. In addition to that, other services such as Simple Network Time Protocol (SNTP) for time synchronization and Simple Network Management Protocol (SNMP) for monitoring of the device can be configured. After this initial configuration has been completed, the device can be accessed through the network using the built-in web interface for the videoconference unit. The next step in the configuration would be to setup either the H.320 (ISDN) or H.323 (IP) services and to test connectivity to a test unit. Any other peripherals could then be attached and tested to ensure proper functionality. If the unit is to be used with a bridge, the administrator of the bridge will provide the necessary information to ensure that the video unit can be correctly identified and connected to the bridge.

What kind of space is needed for live interactive telemedicine?

Live interactive telemedicine equipment can be mounted on a wall on a mobile cart or a rolling pole. Manufacturer design, screen size and type of unit affect the footprint of the unit. Placement and storage of any peripheral devices should also be considered when assessing space needs and mounting options. Consideration should also be given to determining how the unit will be secured or stored when the device is not in use.

Special consideration should be given to wall color, lighting and sound. The colors that have proven successful in telemedicine are light blues and blue grays. These colors provide a nice contrast to skin tones that allow providers to capture relevant clinical information visually from the patient. Lighting should be sufficient to illuminate the area, especially from behind the camera. Volume levels should be set so that the patient can comfortably hear the provider, but not so loud that those in nearby areas can overhear the conversation. To eliminate hollow, tinny sound, it is best to have objects that can absorb sound. In some cases, sound absorbing panels can be installed to dampen the sound from traveling to other areas. Microphone placement is likewise important so that sound the microphone does not pick up the sound coming from the speakers, which would create an echo. Speech should be at normal levels. Patients, providers, and clinical presenters should not need to elevate their voices in order to be clearly heard and understood. Sufficient space should be allowed in the exam room between the patient and the equipment so that the provider can position the camera to achieve their desired view of the patient.

For wall mounted installation, there will need to be enough room on the wall to mount the camera, monitor, speakers (if not built into the monitor), and the CODEC. Consideration should be given to cable management to ensure cables are not tangled and damaged. There are many wall mount solutions that are specifically designed for telehealth installations. These have shelves for placement of all of the necessary components. The space will vary, primarily due to the size of the monitors. It is important to remember that proper installation requires that the wall mount brackets which will support the monitors be either stud mounted or properly anchored to prevent the equipment from falling.

What kind of space is needed for store and forward telemedicine?

Store and forward telemedicine equipment comes in many different shapes and sizes depending on the clinical application. Store and forward dermatology uses a digital camera to capture images and
requires little space except a secure place to store the camera and accessories. Equipment for capturing
digital retinal images used for diabetic retinopathy screening, comes in different sizes ranging from digital
cameras to larger units designed to support the patients head during image capture. No matter what the
size of the equipment, the space should allow for proper use of the equipment while considering the
comfort of the patient.

Home monitoring equipment does not usually require a lot of physical space, but it is important to set it up
near an electrical outlet and a phone connection.

**How much space is needed for distance learning?**

Distance learning and telehealth equipment is usually installed in conference rooms and can be either wall
mounted or on a cart. The presenting site is typically also a conference room where individuals gather to
watch the presentation in person. In some cases, the equipment is integrated into the room. This means
that wiring and equipment are installed so that they are not visible to the occupants. This could be in an
A/V room specially designed for this purpose or in a closet nearby the conference room. The largest piece
of equipment in almost all distance learning and telehealth installations are the video displays. These can
vary in size and number. It is important to remember that proper installation requires that the wall mount
brackets which will support the monitors be either stud mounted or properly anchored to prevent the
equipment from falling. Some additional consideration should be given to the acoustics of the room and the
need for proper sound, proper lighting, avoidance of glare from windows and outside lighting which could
whitewash the room at certain times of the day, and proper placement of the monitors so that all attendees
have an adequate view.

**How much training will I need to operate the equipment?**

Training plays a key role in ensuring success of your telehealth program. If staff are not comfortable with
the telehealth equipment, they will be less likely to use it and patients may likewise feel apprehension to
using the technology. If staff are in control of using the equipment, the patient will more likely be at ease.
The level of training needed depends on the role and responsibilities of each staff member. The simple
answer is that patient and provider site staff will need sufficient training to feel comfortable handling
assigned responsibilities that include interacting with and operating the telehealth technology. Some staff
adapt quickly to the technology, while others may need additional opportunities to become comfortable
with use of the equipment.

Proper training should also be given by qualified individuals in the use of specialized peripherals such as
otoscopes, stethoscopes and cameras to assure appropriate capture of images or sounds. Additional
training should be given to IT staff so that they understand how the equipment functions. This will allow
them to quickly troubleshoot or escalate problems should they arise. In the absence of local IT support, it
may be worthwhile to have a qualified consultant available who can provide technical assistance should it
become necessary.

It is also important to remember that training needs to be ongoing and should not just occur at the be-
ingenning of your telehealth program. An ongoing training program will ensure that new staff are properly
trained and existing staff maintain their skills. Many telehealth programs regularly evaluate staff at regular
intervals to assure that skills are up to date. Additional training must also be given when new equipment or
new sites are added to the telehealth program.
What technical support is needed for a successful telemedicine/telehealth program?

Telehealth technology can be very complex and requires that clinical and support staff are properly trained to address problems when something is not working. It is advisable to have a binder that includes troubleshooting steps, equipment information, and who to call for further assistance. This may include the IT department, telecommunications provider, videoconference equipment vendor or the remote site. Having well documented contact information will assure prompt resolution of problems. Over time, all of these contacts are likely to change so it is important to regularly review this information and update it as needed.

A simple way to prevent technical problems during clinical visits is to test the equipment and connections frequently and to connect sites early enough to address issues before clinics begin. This is especially true if the equipment is not used often or if you are connecting with a site for the first time. Because patient care is involved, it is imperative that priority is given to resolving telehealth related technical issues.

How do I integrate an Electronic Health Record system with my telemedicine program?

If an Electronic Health Record (EHR) system is implemented at your facility, you can incorporate the use of that technology with telemedicine technology. When a patient is referred to a specialist, they will likely request a copy of certain information, such as a patient demographics, problem list, medication list, allergies, social history and family history. An EHR can transfer a Continuity of Care Record (CCR) or a Continuity of Care Document (CCD), a snapshot of a patient’s information useful when referring to a specialist. EHRs eliminate the need to fax paper records between the patient and provider site, removing one of the labor intensive inefficiencies of working with paper records in the telehealth environment.

Where can I go for assistance?

For more information please contact a Telehealth Resource Centers. They can provide qualified experts and/or consultants, and often have tools and templates to assist in the process of developing your telehealth program. For a list of regional telehealth resource centers go to www.telehealthresourcecenters.org.
tab 6 goes before page 140
Table of Contents

Introduction ..........................................................................................................................................................1

The Need for Diabetic Retinopathy Screening Programs .........................................................................1

Guidelines for Referring Patients ..................................................................................................................2

Program Validation – Defining Program Goals and Performance ..............................................................3

Program Models for Diabetic Retinopathy Screening .................................................................................3

Program Personnel and Operations ..............................................................................................................5

Policies and Procedures .................................................................................................................................8

Technical Requirements .................................................................................................................................9

Glossary of Teleophthalmology Terms ........................................................................................................15

References ......................................................................................................................................................17

Appendix: Sample Protocols ..........................................................................................................................18

About the Author:

Jorge Cuadros, OD, PhD, is Director of Informatics Research, University of California Berkeley Clinical Research Center, School of Optometry. Starting in 1994, Dr. Cuadros has developed several programs for remote clinical diagnosis and distance learning, including programs in China and Latin America. Dr. Cuadros’ EyePACS system was developed at the UC Berkeley School of Optometry as an open access system for clinical communication in eye care, and has been used for teleconsultation, retinopathy screening, nursing home care, education, digital grand rounds, and research. He is also co-editor of an international collaborative book, “Teleophthalmology” which was published in February 2006.
Introduction

By far, the most common use of telemedicine in eye care is detection of diabetic retinopathy using asynchronous or store-and-forward (SAF) telemedicine. This has proven to be a viable and less expensive alternative to real-time telemedicine in ophthalmology and has been increasingly used for diabetic retinopathy screening for nearly two decades. Thousands of sites across the United States are now performing diabetic retinopathy screening remotely via several varieties of SAF.

This guide presents the practical aspects of developing a diabetic retinopathy screening (DRS) program along with general guidelines and recommendations for performing DRS based on experiences in community clinics in California. A comprehensive set of guidelines describing requirements and recommendations for DRS is available from the American Telemedicine Association’s (ATA) Ocular Telehealth Special Interest Group.1

The Need for Diabetic Retinopathy Screening Programs

Diabetic retinopathy (DR) is a microvascular complication of diabetes where leakage and blockage of small vessels in the retina cause swelling of retinal tissue, abnormal blood vessel growth, cell death, and retinal detachments. DR is the leading cause of blindness among working age adults in the United States. Vision loss can be prevented in most cases by performing retinal laser photocoagulation in a timely manner.2 Although early detection and treatment of sight threatening DR can prevent blinding complications, less than half of all diabetics receive recommended yearly eye examinations.3

Primary health care providers have traditionally referred their patients to eye care providers for the annual diabetic retinal exam. Patients often fail to visit referred eye care providers for timely eye exams because of geographic, social, economic, and other barriers. Failed visits lead to preventable complications, including blindness from diabetes, glaucoma, and other diseases. DRS via telemedicine can effectively detect sight-threatening DR in the primary care setting, and can often detect other previously undetected diseases, but it does not yet take the place of a comprehensive eye examination. Problems such as cataracts and refractive errors have not been proven to be adequately assessed via DRS; therefore all patients are encouraged to continue with their routine eye care. Future advancements and experience with remote monitoring and diagnostic technology will facilitate the development of comprehensive blindness prevention programs in primary care through telemedicine.
Screening Feedback

Patricia Andrade, Age 32, Diabetic Patient: I didn’t know I could go blind from diabetes until I visited my [primary care] doctor…I had never had an eye exam before, and her assistant took pictures of my eyes with a special camera, and I learned how my eyes could end up and how they were already bleeding inside.

Lyn Berry, MD, Director of the Diabetes Clinic of Alameda County Medical Center: We found that our compliance rate with diabetic retinal exams went from around 25% up to the high 90’s. We feel that we’ve actually been able to prevent advanced eye disease and blindness, and it’s really been an enormous quality tool for our clinic.

David Martins, MD, Medical Director T.H.E. Clinic: My patient recently went blind waiting for a routine eye exam. I could not take that any more, so I instituted diabetic retinopathy screening in my clinic to identify our patients who are at risk, and prevent diabetic blindness.

Guidelines for Referring Patients

The following guideline summary is presented for better understanding of the screening process. Diabetic retinopathy screening does not take the place of a comprehensive eye examination by an optometrist or ophthalmologist. The guidelines are derived from the Position Statement of the American Diabetes Association in cooperation with the American Optometric Association (Michael Duneas, OD), and the American Academy of Ophthalmology (Donald S. Fong, MD, MPH). Readers are advised to view the complete position statement.

1. Patients with type 1 diabetes should have a retinal examination 3–5 years after the onset of diabetes. In general, evaluation for diabetic eye disease is not necessary before 10 years of age. However, some evidence suggests that the prepubertal duration of diabetes may be important in the development of microvascular complications; therefore, clinical judgment should be used when applying these recommendations to individual patients.

2. Patients with type 2 diabetes should have a retinal examination shortly after diabetes diagnosis because the onset of the disease may occur several years before the diagnosis. Subsequent examinations for both type 1 and type 2 diabetic patients should be repeated annually. Examinations will be required more frequently if retinopathy is progressing.

3. When planning pregnancy, women with preexisting diabetes should have a retinal examination and should be counseled on the risk of development and/or progression of diabetic retinopathy. Women with diabetes who become pregnant should have a retinal examination in the first trimester and close follow-up throughout pregnancy. This guideline does not apply to women who develop gestational diabetes, because such individuals are not at increased risk for diabetic retinopathy.
Referring Patients with Sight-threatening Diabetic Retinopathy

Patients with any level of macular edema, severe nonproliferative diabetic retinopathy (NPDR), or any proliferative diabetic retinopathy (PDR) require prompt care of an ophthalmologist who is knowledgeable and experienced in the management and treatment of diabetic retinopathy. Referral to an ophthalmologist should not be delayed until PDR has developed in patients who are known to have severe nonproliferative or more advanced retinopathy. Early referral to an ophthalmologist is particularly important for patients with type 2 diabetes and severe NPDR, since laser treatment at this stage is associated with a 50% reduction in the risk of severe visual loss and vitrectomy.

4. Patients who experience vision loss from diabetes should be encouraged to pursue visual rehabilitation with an ophthalmologist or optometrist who is trained or experienced in low-vision care.

Program Validation – Defining Program Goals and Performance

The Ocular Telehealth section of the American Telemedicine Association defined four categories of performance of DRS programs using the Early Treatment Diabetic Retinopathy Study (ETDRS) film-based retinopathy diagnosis system as the gold standard:

A. Category 1 validation indicates a system can separate patients into two categories: those who have no or very mild nonproliferative and those with more severe levels of DR. This level generally identifies patients who may potentially require the care of an ophthalmologist within a year.

B. Category 2 validation indicates a system can accurately determine if sight-threatening DR as evidenced by any level of macular edema or severe diabetic retinal changes. This category of validation allows identification of patients who do not have sight-threatening DR and those who have potentially sight-threatening DR. These patients with sight-threatening DR generally require prompt referral for possible laser surgery.

C. Category 3 validation indicates a system can identify ETDRS defined levels of nonproliferative DR (mild, moderate, or severe), proliferative DR (early, high-risk), and macular edema with accuracy sufficient to determine appropriate follow-up and treatment strategies. Category 3 validation allows patient management to match clinical recommendations based on clinical retinal examination through dilated pupils.

D. Category 4 validation indicates a system matches or exceeds the ability of ETDRS photos to identify lesions of DR to determine levels of DR and DME. Functionally, Category 4 validation indicates a program can replace ETDRS photos in any clinical or research program.

The cost and complexity of performing DRS generally increases with higher category of validation. DRS program administrators must determine the appropriate program goals and performance and select a service that matches these expectations.

Program Models for Diabetic Retinopathy Screening

Organizations must consider how to adapt telemedicine based diabetic retinopathy screening to their clinicians’ workflow without disrupting their work while ensuring that all patients who require screening are attended to. Three predominant strategies have emerged to manage screening:
1. **Appointments for Retinopathy Screening.** The most obvious and intuitive option is to set up appointments for diabetic patients to return for retinal imaging. An appointment schedule is set up when screening personnel process patients to be screened. Unfortunately, many patients fail to return for the retinal imaging, just as they often fail to attend an eye exam.

2. **Integrating Screenings into Clinic Workflow.** The success of any clinical program depends on how well it is integrated into the workflow of the care process. One straightforward way to ensure that this happens is to create a simple set of clinical scenarios and then map out suggestions for a modified workflow, including alerts and reminders for all the people involved with the patient. For diabetic retinopathy screening, there are a few basic scenarios:
   a. Clinical Scenarios
      i. Current diabetic patient visiting the clinic for a regular exam or unrelated issue. The key is for physicians and case managers to have retinopathy screening at the front of their minds. They should be making referrals for retinopathy screening to all diabetic or borderline diabetic patients.
      
      ii. Current diabetic patient who is not scheduled for a clinic visit. Many diabetics have never had a retinopathy screening and do not know that it is necessary. Others may have received a retinopathy screening more than a year ago and are due for another screening. Patient outreach — mailings and phone calls — can educate these patients and motivate them to schedule a visit. Electronic registry systems can help simplify identification of patients needing screens and outreach.
   
   iii. New diabetic patient who visits the clinic specifically for retinopathy screening. One result of community outreach is that new patients may come to the clinic just to have their eyes tested for retinopathy. Since retinopathy screening is part of a whole program of diabetes management, it is critical to provide these patients with a more comprehensive care program.

3. **DRS Events.** Diabetic patients are gathered at an event where they can be screened for retinopathy. Diabetes education seminars, health fairs, or other community events are often excellent locations for performing DRS. Care should be taken to include all patients, not just the compliant patients who are most likely to attend these events.

---

**Typical Diabetic Retinopathy Screening Workflow:**

- **Check-In:**
  - See if patient is up to date on screening

- **Physician:**
  - Refers all diabetic patients for screening

- **Photographer:**
  - Captures and uploads images and clinical data

- **Consultant:**
  - Interprets images and creates report

- **Physician or Case Manager:**
  - Communicates results to patient and makes referral if needed
Tip for Workflow Integration:
Use charts and notes as reminders for referrals. If possible, make retinal screenings available without an appointment so that a patient who is already in the clinic does not have to schedule a return trip for the screening. (Many patients do not comply with scheduled return visits.) If electronic registry systems are available, set up alerts and reminders for annual eye exams.

Program Personnel and Operations
In addition to the technical requirements, a successful retinopathy screening program must have organizational features in place.

Personnel involved in the screening include:

- primary care clinicians who refer patients for DRS
- photographers who acquire and transmit retinal images
- reviewers who interpret images and generate assessments of retinopathy
- administrators who oversee the process
- technical personnel that develop and maintain the technical components of the system

DRS programs also require policies and procedures including:

- templates and protocols to manage data
- procedures for interfacing with medical records, billing, and administrative tasks.

A DRS requires a primary care provider, photographer, clinical consultant, administrator, and technical support. The following are recommendations for ensuring adequate assignment of personnel for DRS.

1. Primary Care Providers
Primary care providers are usually in charge of coordinating the care of their chronic disease patients so it is crucial that they understand and agree about the importance of on-site DRS. Any DRS program should include meetings with all providers and staff to present the rationale for the program, address any concerns, and develop the processes and protocols for referring patients for screening and subsequent care. These meetings should occur early in the program development process.

Five typical concerns of primary care providers are:

- Duplication of services with regular eye exams with eye care providers. Why perform DRS if patients are already getting eye exams? Review of a clinic’s own compliance level with yearly eye exams (usually less than 50%) can effectively address this concern, given that high risk patients are often the least likely to receive yearly eye exams. Furthermore, eye exams reported by patients are often not accurate. Patients often state that they have had a DR exam when they have only had a simple eye exam for eyeglasses or visual acuity. Patients sometimes misunderstand the results of their retinal exams or can’t effectively relay the pertinent information to their primary care provider. Often the reports from the eye care providers are not available in the patients’ records. It is important to emphasize that DRS does not take the place of a regular eye exam, whereas, DRS is more effective for detecting retinopathy.
• DRS requires the participation of high level clinicians, taking resources away from other necessary services (lost opportunity cost). The DRS process requires minimal to no active participation by physicians. The photography and communication can be managed by medical assistants, interpreters, volunteers, and others (see section on photographers below).

• Insufficient resources for treating patients with detected retinopathy. Providers are sometimes concerned that patients that are found to have sight-threatening retinopathy will not have access to treatment. This is a real concern (discussed further in the section on follow-up), however, the rationale for screening at the primary care site is to refer only those patients with sight-threatening conditions to the local retinal specialists, thereby preserving retinal specialist resources for treatment, rather than using their time to see diabetic patients that don’t have serious retinopathy. Furthermore, it is usually better for the patient to be aware of sight-threatening retinopathy rather than to think that the eyes are normal.

• Inadequate follow up on referrals. Who will refer the patient in the event of a positive finding on the screening? The clinic and off-site retinal consultants must have a mechanism for ensuring that patients can be contacted and referred to appropriate eye care providers in the event that serious retinopathy is found. Primary care providers should use their regular specialty referral mechanisms to follow up with patients.

• Inadequate validation of DRS and reading consultants. Several landmark studies have validated the use of digital retinal imaging, summarized by John Whited for the US Veterans Administration. Ensuring that the proposed DRS is validated against the standard programs should effectively address this concern.

2. Photographers
Digital retinal photography is generally much easier to learn than film-based retinal photography. Personnel at all levels can usually be trained to perform adequate digital photography in a matter of hours. Sites that perform DRS have designated medical assistants, x-ray techs, interpreters, volunteers, medical and pre-medical students, optometric interns, diabetic care coordinators, diabetic educators, nurses, and doctors to acquire retinal images. High level personnel (e.g. nurses and educators) may use retinal images to educate patients and to assess their general microvascular status; however, all levels of photographers can acquire adequate images for DRS.

Individuals that are well-suited as retinal photographers have the following qualities:

• Familiarity and comfort with technological devices, such as digital cameras, video games, and computers.

• Patience in working with patients.

• Attention to detail. Consistently high quality images are important for the success of DRS.

• Dedicated time for performing the photography. If the photographer has too many other assigned activities, then DRS may be avoided.

• Enthusiasm for DRS. Most photographers soon become enthusiastic about performing DRS, which creates motivation to overcome the changes to clinic activities that are necessary during the initial phase of the DRS program.

Certification of photographers is important to ensure consistently adequate images. Certification programs for photographers are available through the University of Wisconsin Fundus Photograph Reading Center.
Continuous quality improvement should also be implemented by tying quality assessment of retinal images with the remote clinical consultation. The clinicians that interpret the images should provide feedback to the photographers regarding the quality of their images. Retraining and remediation can then follow the consultants’ feedback.

3. Clinical Consultants
The professionals that read transmitted retinal images for DRS programs are varied and can be anywhere in the world. DRS programs have used retinal specialist ophthalmologists, general ophthalmologists, optometrists, or trained non-clinical staff. Most programs, including Kaiser Permanente and the Veterans Administration, have employed both ophthalmologists and optometrists to read images, while others, like the University of Wisconsin Fundus Photograph Reading Center, have employed trained non-clinical staff to interpret images using a highly developed lesion detection protocol.

Following are qualities of clinical consultants that should be considered when selecting and contracting with appropriate consultants:

- Experience
- Capacity
- Availability
- Cost
- Liability
- Turnaround time

Certification and quality assurance of clinical consultants is of utmost importance. Inconsistent assessments and recommendations among consultants can cause uncertainty regarding the disposition of screened patients. A certification program “calibrates” consultants and allows for better quality assurance of the DRS program. Certification programs for consultants are available through the University of Wisconsin Fundus Photograph Reading Center.

4. Administrators
In most retinopathy screening programs, high-level administrators participate in the initial interactions to review the expected benefits and costs of the program. Once the decision has been made to incorporate retinopathy screening in a clinic, the administration will usually assign a project manager who will perform the following on-going administrative duties:

- Manage schedules and duties of photographers and assistants involved in the day-to-day processing of encounters
- Coordinate billing for services
- Manage referrals for treatment of patients by retinal specialists
- Act as liaison between retinal consultants and the clinic
- Communicate technical difficulties to retinal camera vendors
- Ensure compliance with DRS policies and procedures
- Generate reports on performance of program
A Note to CEOs, Operations Directors, and Clinic Managers

There are a few key ways that administrators can ensure a successful diabetic retinopathy screening program:

1. Communicate your support for the program at its inception and on an ongoing basis—your buy-in is absolutely essential in motivating the clinic staff. Ask for updates at staff meetings, and promote the clinic’s goals, milestones, and successes.

2. Take a team approach to integrating screening into clinic workflow, enlisting the support of case managers, providers, photographers, and support staff. This may require the flexibility to accept walk-in appointments for people who were not aware at the time of making their appointment that they should be having retinopathy exams.

3. Emphasize the critical role of primary care in overall management of diabetic eye health. Make sure that everyone at the clinic understands that screening is part of every diabetic’s care management program at the normal site of care, not something performed only by specialists.

4. Embrace telemedicine as a new model of care, communicate with IT professionals to ensure their support, and educate your clinic team about the key benefits of this approach, including speed of service, ease of process, lower costs, and better patient care.

5. Provide training, support, and recognition for staff to fit retinopathy screening into a comprehensive diabetes management plan. Make sure that participation in the program is reflected in performance measures.

Policies and Procedures

The success of a diabetic retinopathy screening program can be measured by the percentage of diabetic patients who receive annual retinal examinations. Close attention to identifying diabetic patients who have not had a retinal examination within one year will ensure that all patients will receive appropriate care. The following are recommendations about identifying patients for retinal screening that have proven effective to ensuring a high level of compliance with yearly retinal exams:

- Identify and screen diabetic patients without requiring a referral from the primary care provider. Providers are often very busy and will neglect to initiate the referral for screening. Diabetic registries or electronic medical records are often effective in identifying patients that need DRS.

- Screen all diabetic patients regardless of previous eye exams. Patients often report having had a regular eye exam, but a report of the findings is not available in the patient record. Patients are sometimes mistaken when they receive a simple eye examination for eyeglasses, thinking that a thorough view of the retina was performed.

- Closely follow patients that fail the screening and are referred for retinal treatment. Diabetic retinopathy is often asymptomatic, even in the late stages, and patients will often neglect to obtain treatment. It is incumbent upon the primary care staff, as well as the retinal consultants, to ensure that the patient actually receives proper treatment.

Three sample protocols on screening services, photography review and pupil dilation can be found in the Appendix.
**Technical Requirements**

Diabetic retinopathy screening programs generally use store and forward technologies (SAF). A SAF telemedicine program generally relies upon a similar set of concepts and components, regardless of specialty, and a typical DRS program follows this similar format.

First, there must be a device used to capture imagery or data from the patient at a point in time. For DRS, there are a number of digital retinal imaging devices in common use. These vary significantly in both cost and features, and any prospective screening site should consider their needs, the needs of the referral specialist, and the capabilities of their staff when choosing a device.

Second, there must be access to an imaging and archival system for storing the images and clinical data, as well as a communications system for transmitting the images and data between the patient care site and consulting specialists. In many SAF disciplines, some systems are based on a central data repository referred to as “PACS” (Picture Archiving and Storage Systems). In other cases, PC-based image management and communications software systems concentrate on secure transmission of patient information from point to point, without the additional investment in central archiving. The example illustrated in this guide, EyePACS, is an open source transmission and archiving system.

Finally, there must be a system in place on the consultant’s side which allows review and analysis of the imagery and data at an appropriate resolution and format. In the case of DRS, a viewing station is required for the consultants to view and interpret cases.

**Connectivity**

Because a DRS is an asynchronous program by nature, the connectivity requirements are generally more modest than those required for live interactive telemedicine protocols, and even less than those required by other SAF protocols which generate huge files, such as echocardiography for example. A successful DRS program can operate within the following connectivity and configuration parameters:

- Allows upload of image files to a trusted site
- Allows Secure Socket Layer (SSL) encryption at 128 bit strength in web browser
- Allows connections via VPN to imaging computer through network (for managing computer)
- 128 Kbps minimum connection to Internet

If the clinic will assign its own computers for the program then it must meet these minimum specifications:

- CPU: 2 GHz
- Hard Drive: 40 Gb – 5400 rpm
- RAM: 512 MB
- Two standard USB2 inputs
- Video Card: 128 Mb vRAM; supports 1152 X 864 resolution in 24-bit color
- Network Interface Card: 10 Mbps minimum
- Latest virus protection and operating system updates
- Monitor: 15” Flat screen or flat panel; 60 Hz refresh rate
- A printer for printing retinopathy reports (just text) can either be connected directly to imaging computer, or connected via the network.
The room used for DRS must be able to be darkened so that patients’ pupils will dilate. Completely dark is preferable. There should be at least four electrical outlets available for imaging devices and computer. The maximum electrical requirement for all devices is approximately 5 Amps. There should also be a plain telephone line and telephone installed at the work station available for service calls, troubleshooting, and patient consults.

A comprehensive review of all retinal imaging modalities is well beyond the scope of this guide. Moreover, new imaging devices are quickly appearing on the market at an accelerating rate. Below are considerations that may be helpful in determining which devices are appropriate for a particular DRS program. Many diverse retinal imaging products are sold to eye clinicians. Prices for retinal imaging devices vary greatly and the quality of the acquired images also varies greatly.

Retinal imaging devices generally work by shining light (plain or laser) through the pupil of the eye to illuminate the retina. Lenses inside the device focus light from the retina onto camera sensors that convert the light into signals that are interpreted by a computer and rendered onto a viewing monitor or stored in computer files. The quality of the images that are viewed by the eye consultant depends on each link in this chain of events. The various factors that ultimately affect the quality of the displayed images include resolution, color, stereopsis (depth perception), image compression, and pupil dilation. These factors are discussed in the following sections.

**Resolution**

The optimum image resolution has been actively debated since the beginning of digital retinal imaging. Resolution of a digital retinal image is the number of pixels (the smallest elements of a digitized image) that are assigned to represent a given area of retina. High resolution images have finer detail, but they also require larger files for storage and more time for processing and transmission. Early digital retinal imaging devices (circa 1990) used video cameras mounted to adapters on the camera ports of film based retinal cameras. Images were acquired using video capture cards inside computers that digitized analog video still frame signals. The typical image resolution was 640 X 480 pixels over a 30 to 45 degree circular field of the retina. Many clinicians felt that these images were sufficient to detect retinal abnormalities. Clinical studies, however, showed poor correlation with face-to-face examinations or film transparencies. Since then, image resolution has steadily increased. Most of today’s retinal cameras have one million or more pixels of resolution on the image sensors. Jensen and Scherfig found that 3 million pixels was the minimum resolution required for a digital camera to capture images comparable to slide film. Tom Cornsweet explains in “The Great Pixel Race”, however, that a camera sensor’s resolution is not equivalent to the acquired retinal image resolution. He notes that there is a limit to the benefit of adding more pixels to a sensor. This limit is set by the optical quality of the eye that is being photographed. The size of the captured field in the retina also greatly affects the resolution. A 45 degree field requires more than twice as many pixels as a 30 degree field. Cornsweet also indicates that most digital cameras have rectangular sensors. A third or more of the space on rectangular sensors is wasted because retinal images are round. A square sensor would require less resolution than a rectangular one because less space would be wasted. Lastly, resolution is greatly affected when capturing color vs. grayscale (“black and white”) images. More than twice as many pixels are needed to capture a color image than to capture a grayscale image because color pixels must be divided among the different wavelength sensors in order to get color images, whereas grayscale pixels match the image point for point. This leads to the question of whether color is necessary for retinal imaging in diabetic retinopathy, or is grayscale adequate for image interpretation.
**Color**

Rendering retinal images in color or grayscale, and how to do it, is open to debate. Although there are many different ways to analyze color, a color retinal image is typically separated into three components or channels: red, green, and blue. A more detailed discussion of digital color image theory can be found in Ken Davies’ discussion of digital color models. Investigators generally agree that the green channel of a retinal image contains most of the important information regarding diabetic retinopathy. Clinicians often use green filters to isolate the green channel in order to enhance retinal lesions when viewing the retina with biomicroscopy. Many clinicians, however, prefer to view color images of the retina, perhaps because they are more accustomed to it. Hence, designers of monochrome retinal imagers often “colorize” the grayscale images in order to provide a more normal appearance for the display. Ultimately, the choice of grayscale vs. color imaging will be a matter of preference. Grayscale sensors may be more frugal in their use of pixels, but greater numbers of pixels are rapidly becoming easier to manage and cheaper to make and purchase.

Several parameters affect the appearance of digital color images. The color depth is one of the most important parameters that affects how well subtle differences in colors and shading are rendered. Images should be captured in a minimum of 24-bit color (16 million possible colors) and displayed as well with a minimum of 24-bit color. The hue, saturation, and brightness are other parameters that can be adjusted both on the acquisition side and on the display side; however, there is no standard guidelines as to how these should be set. Color matching products are available to insure that displays match the original image, however, these may not be so important since the human eye readily adapts to changes in surrounding colors. Moderate mismatching of colors among different computer monitors and display devices does not greatly influence the ability to detect lesions.

**Stereopsis**

Stereopsis (depth perception) allows observers to perceive variations in the thickness of the retina. Stereopsis is useful for evaluating edema, the accumulation of fluid in the retina. Edema comes from leaky blood vessels and damaged tissue, which in turn disrupts sensory cells. Detection of edema that is in and around the macula, the central most sensitive area of the retina, is particularly important since this is one of the main causes of blindness from diabetes. A stereoscopic image is actually composed of two images, one for the observer’s right eye and one for the observer’s left eye. The observer perceives stereopsis when the two images are combined in the observer’s brain. To acquire a stereoscopic pair from an ordinary retinal camera, the photographer takes one picture of the retina, then rotates the camera slightly and takes another picture of the same field. Alternatively, with some cameras, stereoscopic images are rendered by combining overlapping areas of different fields. Some retinal cameras, such as the Nidek 3DX, Visual Pathways ARIS, and the Clarity Pathfinder, can acquire both right and left stereoscopic images simultaneously.

There are a few different ways to view digital stereoscopic images once they are acquired. The simplest is to place the stereoscopic pair side by side on a computer screen (or screens), then cross the eyes or use prisms or mirrors to overlay the image in the observer’s right eye onto the image in the observer’s left eye. After some practice fusing images becomes easier and it often becomes unnecessary to use prisms or mirrors. This method requires no special software and can be viewed on any monitor. At UC Berkeley, the retinal reading stations have dual computer monitors where the stereoscopic pair is rendered over the span of the two monitors allowing a larger area to be viewed in stereo.
Another way to view images in stereo is to use special “shutter” eyeglasses that are connected to the computer’s video card. Right and left stereoscopic images are alternately displayed at 60 times per second or faster while the eyeglasses are synchronized to alternately block the view of one eye. Disadvantages are that the images may be dimmer and it is necessary to use proprietary software and eyeglasses to create and view the images on the observer’s work station. Still another option is to use recently released computer monitors that can render stereoscopic images without having to use special eyeglasses to view them. These monitors display the two images in alternating vertical strips which are then directed alternately to either the observer’s right or left eye. The disadvantages of this strategy includes costly monitors for all viewing stations, special software to render the images, and only one observer can view stereoscopic images at a time.

UC Berkeley’s DRS photography protocol uses three overlapping fields which contain images of the optic nerve and macula that can be combined for stereoscopic viewing.

Although stereoscopic viewing of the retina is the gold standard for diabetic retinopathy detection, many, if not most, screening programs do not use stereoscopic viewing. Retinal edema is a significant finding for assessing diabetic retinopathy; however, many clinicians feel that it does not affect their referrals to specialists unless the edema is in or around the macula. Bresnick et al\(^{11}\) found that the presence of hard exudates (fatty protein leakage from damaged blood vessels) within about 1500 microns of the macula detected clinically significant macular edema (CSME) with a sensitivity of 94% and specificity of 54%. This means that almost all patients with CSME will be detected and about half of those patients who are found to have CSME will not actually have it. Many clinicians feel that the 2-to-1 over-referral rate caused by using this guideline is acceptable because the consequence of a false positive result is simply an eye examination.

### Compression

Compression allows digital images to be stored in small computer files. Smaller files make it more efficient to store, retrieve, and transmit images. Without compression some retinal images would be too large to be practical for telemedicine. There are many ways to compress images. Some methods, such as JPEG and PNG, are standard compression formats and the programs necessary to display these images are already in any typical computer or Internet browser. Some compression methods are proprietary and users are required to install or download special programs in order to view images in these formats. Some compression methods are “lossless”, which means that they are exactly like the original uncompressed image when they are displayed. Others are “lossy”, meaning that they may look like the original image, but some fine detail and image information may be lost.

Some diabetic retinopathy screening programs use only uncompressed images due to concerns that misinterpretation of compressed retinal images may create legal liability. Some studies have compared graders viewing retinal images with lossless compression and “lossy” compression. Although they may not be definitive, the results generally indicate that compression up to about 15 to 1 level (i.e. the compressed image is roughly one fifteenth the size of the original) does not significantly affect the grading of retinal images.\(^{12}\) Significant image degradation occurs, however, when images are enhanced or modified after they are compressed.

A system using a fiber optic network with no limitation on data storage would perform well with uncompressed retinal images. Many primary clinics, however, have far more modest bandwidth connectivity and must transmit images in the most efficient way possible. The UC Berkeley Retinal Reading Center allows transmission of uncompressed images, but encourages the use of compression no greater than 15 to 1. UC Berkeley uses the JPEG format for compressed images because it provides adequate image quality and is widely accessible through almost all imaging programs and web browsers.
Enhancement
Some developers of retinopathy screening programs recommend that images should be stored as “raw” images for medico-legal reasons in order to ensure that detected lesions are actually present and are not artifacts of the enhancement. A typical digital image, however, goes through several image processing steps before it is rendered on a display, so it becomes unclear at what stage is an image still “raw”. In addition, a significant number of popular applications do not support direct display of .RAW image files. In practice, high quality JPEG images have proven more than adequate for the screening process.

Pupil Dilation
Many retinal cameras, such as the Canon DGi, and the Topcon NW-200, do not require pupillary dilation for retinal photography. Even with these cameras, however, images are often of better quality when they are taken through dilated pupils. Approximately 10% of images that are acquired without pupillary dilation with non-mydriatic retinal cameras can not be appropriately interpreted by clinicians due to poor image quality. Two factors that affect image quality are small pupil size and media opacities, such as cataracts. These limitations can be overcome by temporarily increasing the pupil size with pharmacological agents. Better images can be acquired more quickly when pupils are dilated, particularly in older patients, since they are more likely to have small pupils and media opacities. Pharmacological dilation, however, can have adverse effects. The most common adverse effects are photophobia (sensitivity to light) and cycloplegia (inability to change focus, usually causing near blur). Other adverse effects are much less common, and include hypersensitivity, which can cause conjunctival and corneal inflammation and ocular infection from contact with contaminated eye drops. Pupillary dilation has occasionally been reported to cause acute angle closure glaucoma, a painful sight-threatening condition. The use of two dilating agents used in combination for full pupillary dilation has been reported to potentially cause angle closure in approximately one out of five thousand individuals. There have been no reported cases of angle closure caused by using a single dilating agent. One drop per eye of 1% tropicamide can be used as a single agent to provide adequate dilation for retinal photography. Onset of pupillary dilation is approximately 15 minutes and photophobia and cycloplegia will typically last from two to four hours, although a few individuals may experience pupil dilation for up to three days.

A specific protocol for pupil dilation should be followed if eye care professionals are not available to instill eye drops. An example protocol is found in the Appendix.
**Glossary of Teleophthalmology Terms**

**Diabetic Retinopathy (DR)** - Diabetic retinopathy is a microvascular complication of diabetes where leakage and blockage of small vessels in the retina cause swelling of retinal tissue, abnormal blood vessel growth, cell death, and retinal detachments. Diabetic retinopathy (DR) is the leading cause of blindness among working age adults in the United States. Vision loss can be prevented in most cases by performing retinal laser photocoagulation in a timely manner. A detailed discussion of prevention, early detection, evidence-based recommendations, clinical trials, and grading scales is presented in the American Academy of Ophthalmology’s Diabetic Retinopathy Preferred Practice Pattern. Although early detection and treatment of sight-threatening DR can prevent blinding complications, less than half of all diabetics receive recommended yearly eye examinations.

**ADA Guidelines Terms:**

**Macular Edema** – Fluid from leaky blood vessels accumulating around the macula (the center of vision in the retina). Clinically significant macular edema is defined by the ETDRS to include any of the following features:

- Thickening of the retina at or within 500 microns (about one third of the optic nerve head diameter) of the center of the macula.

- Hard exudates at or within 500 microns of the center of the macula, if associated with thickening of the adjacent retina (not residual hard exudates remaining after the disappearance of retinal thickening).

- A zone or zones of retinal thickening one disc area or larger, any part of which is within one disc diameter of the center of the macula.

**Severe NPDR** – Severe Non-Proliferative Diabetic Retinopathy: The cutoff of severe NPDR is derived from the “4-2-1 rule” where presence of the following would qualify for this level if no PDR is present:

- 4 quadrants of hemorrhages or microaneurysms greater than ETDRS standard photograph 2A (> 20 retinal hemorrhages); or

- 2 quadrants of venous beading; or

- 1 quadrant of IRMA equal or greater than ETDRS standard photograph 8A (prominent, easily visible abnormal blood vessels)

**PDR** – Proliferative Diabetic Retinopathy: Neovascularization (new blood vessel growth) and/or vitreous/preretinal hemorrhage (blood in front of the retina).

**IRMA** – Intra-Retinal Microvascular Abnormalities: dilated abnormal capillaries, which are often leaky, and lie in the plane of the retina. They usually occur in areas of widespread capillary occlusion, often associated with occlusion of larger vessels and cotton-wool spots.
**Vitrectomy** - The vitreous is a normally clear, gel-like substance that fills the center of the eye. Advanced diabetic retinopathy may require a vitrectomy, or surgical removal of the vitreous. After a vitrectomy, the vitreous is replaced as the eye secretes aqueous and nutritive fluids.

A vitrectomy may be performed to clear blood and debris from the eye, to remove scar tissue, or to alleviate traction on the retina. Blood, inflammatory cells, debris, and scar tissue obscure light as it passes through the eye to the retina, resulting in blurred vision. The vitreous is also removed if it is pulling or tugging the retina from its normal position.

**ETDRS17 (Early Treatment of Diabetic Retinopathy Study)** - A large NIH sponsored study which measured the effectiveness of early diabetic retinopathy treatment with laser and created a widely accepted scale for staging diabetic retinopathy.
References


Appendix

Sample Protocol 1: Diabetic Retinopathy Screening Services
University of California, Berkeley Retinal Reading Center

**PROCEDURE FOR DIABETIC RETINOPATHY SCREENING SERVICES (DRS)**

<table>
<thead>
<tr>
<th>Department</th>
<th>DIABETES CARE FACILITIES</th>
<th>Effective Date</th>
<th>June 28, 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campus</td>
<td></td>
<td>Date Revised</td>
<td></td>
</tr>
<tr>
<td>Unit</td>
<td></td>
<td>Next Scheduled Review</td>
<td></td>
</tr>
<tr>
<td>Manual</td>
<td>Author</td>
<td>Jorge Cuadros</td>
<td></td>
</tr>
</tbody>
</table>

Replaces the following Policies:

**Policy**

1. All appropriate consents must be obtained for Diabetic Retinopathy Screening Services.

2. All patients must be referred by the primary care physician (PCP) for DRS services based on the following guidelines:
   a. Diagnosed diabetic patients who have not had a retinal exam within the last year.
   b. Completed pinhole test (visual acuity).
   c. Has recent lab results (within the last 6 months), including Cholesterol, Triglycerides, and Hemoglobin A1C.

3. All appropriate documentation must be sent with the referral prior to the DRS services appointment.

4. All photographers providing DRS services must complete Diabetic Retinopathy Screening Photography Training and complete 10 satisfactory sets of images prior to providing DRS patient services.

**Background**

According to the American Diabetes Association, up to 21% of people with type 2 diabetes have retinopathy when they are first diagnosed with diabetes, and most will eventually develop some degree of retinopathy. Diabetes is responsible for 8% of legal blindness, making it the leading cause of new cases of blindness in adults 20-74 years of age. Through the findings of the 2002 Behavioral Risk Factor Surveillance System, the CDC reports that each year, 12,000–24,000 people in this country become blind because of diabetic eye disease. Regular eye exams and timely treatment could prevent up to 90% of diabetes-related blindness. However, only 60% of people with diabetes receive annual dilated eye exams as recommended by the American Diabetes Association guidelines. Some studies have also indicated that preventive ophthalmic surveillance of high-risk diabetic individuals is even worse in urban underserved communities. (Flowers, et al.)
Seven out of every 100 people in California are estimated to have diabetes, a 2.3 per every 100 people increase from 1994. African American, Hispanic, American Indian, and Alaska Native adults are about 2–3 times more likely than white adults to have diabetes. It is estimated at 15% of adult America Indian/Alaska Native have diabetes, 13% of African American, 10% of Latinos, and nearly 8% of Whites. The prevalence of diabetes has increased steadily over the past 20 years, most notably among African Americans. Recent increases have also occurred among Latinos. (CDC)

Dilated comprehensive eye examinations have been demonstrated to be of great potential benefit for diabetic retinopathy. However, with national studies indicating that only 60% of diabetics actually undergo annual dilated examinations and urban underserved communities exhibiting even worse numbers have driven diabetic retinopathy screening models via digital fundus photography into the forefront of diabetes management.

With the introduction of digital fundus cameras, high capacity computers, and the internet, the medical and financial implications of a telemedicine retinopathy screening model has been explored in the past decade. DRS, however, is not a substitute for regular comprehensive eye examinations.

**Procedure**

1. Patients may be appointed for DRS services for same day appointments or for future appointments when same day appointments are not available.

2. The photographer(s) will follow steps in image capture as outlined in EyePACS DRS Photography Manual.

3. Three standard fields and fundus reflex photographs will be captured.
   a. Field 1M – Disc
   b. Field M – Macula
   c. Field 3M – Temporal to Macula

4. Documentation of the service will be inserted in the patient chart by photographer.

5. All images are transmitted via Internet to the EyePACS image server at UC Berkeley.

6. All pictures are stored for transmission for review and consult by credentialed UC Berkeley reviewers. Reports of the retinal screening cases will be appended to digital case presentation usually within one hour, but not more than five days after image capture.

7. Patients needing further retinal services will be referred by photographer to appropriate eye care specialist as indicated in EyePACS report.

8. The photographer assures that all electronically transmitted information is printed and the hardcopy report is placed in patient’s chart or sent to Medical Records for processing according to existing procedures for consult reports.

In the event that adequate images cannot be acquired:

1. If the photographer determines that clear images can’t be acquired, then the patient will be encouraged to go to their general eye exam appointment.
References
ADA Guidelines on Diabetic Retinopathy Screening.


Approvals
(This area can be changed depending on approvals needed. Signatures are required on all new policies)
Sample Protocol 2: Diabetic Retinopathy Photography Review
University of California, Berkeley Retinal Reading Program

**Policy**
1. Optometrists will review digital DRS cases at a web terminal and report to PCP and to tertiary care providers as needed. Optometrists will follow the ADA guidelines for referral.

**Background**
According to the American Diabetes Association, up to 21% of people with type 2 diabetes have retinopathy when they are first diagnosed with diabetes, and most will eventually develop some degree of retinopathy. Diabetes is responsible for 8% of legal blindness, making it the leading cause of new cases of blindness in adults 20-74 years of age. Through the findings of the 2002 Behavioral Risk Factor Surveillance System, the CDC reports that each year, 12,000–24,000 people in this country become blind because of diabetic eye disease. Regular eye exams and timely treatment could prevent up to 90% of diabetes-related blindness. However, only 60% of people with diabetes receive annual dilated eye exams as recommended by the American Diabetes Association guidelines. Some studies have also indicated that preventive ophthalmic surveillance of high-risk diabetic individuals is even worse in urban underserved communities. (Flowers, et al.)

Seven out of every 100 people in California are estimated to have diabetes, a 2.3 per every 100 people increase from 1994. African American, Hispanic, American Indian, and Alaska Native adults are about 2–3 times more likely than white adults to have diabetes. It is estimated at 15% of adult America Indian/Alaska Native have diabetes, 13% of African American, 10% of Latinos, and nearly 8% of Whites. The prevalence of diabetes has increased steadily over the past 20 years, most notably among African Americans. Recent increases have also occurred among Latinos. (CDC)

Dilated comprehensive eye examinations have been demonstrated to be of great potential benefit for diabetic retinopathy. However, with national studies indicating that only 60% of diabetics actually undergo annual dilated examinations and urban underserved communities exhibiting even worse numbers have driven diabetic retinopathy screening models via digital fundus photography into the forefront of diabetes management.

With the introduction of digital fundus cameras, high capacity computers, and the internet, the medical and financial implications of a telemedicine retinopathy screening model has been explored in the past decade. Although the quality of fundus photography has not been proven to be a suitable substitute for a dilated comprehensive eye exam done by an ophthalmologist or optometrist, there have been some examples of beneficial outcomes.
**Procedure**

1. Attending optometrist receives notification of cases to review.

2. Attending optometrist reviews images and case information and follows the ADA guidelines for referral of sight-threatening retinopathy.

3. Attending optometrist generates a report in EyePACS usually within one hour, but not more than 14 days from date of e-mail notification. Report indicates findings, impressions, and advice.

4. Notification that report has been generated is sent to referring clinic.

In the event that adequate images cannot be reviewed:

1. If the images that are transmitted are not of sufficient quality to make an assessment, then e-mail notification will be sent back to referring clinic recommending that patient be encouraged to attend their general eye exam appointment.

In the event that patient needs referral for tertiary care:

1. If the reviewing optometrist determines that patient requires a referral to ophthalmology services, notification will be sent along with report indicating need for further study or treatment with appropriate specialist.

2. Primary care clinic staff will follow regular referral procedure to refer patient to ophthalmology clinic.

**References**

ADA Guidelines on Diabetic Retinopathy Screening.


**Approvals**

(This area can be changed depending on approvals needed. Signatures are required on all new policies)

<table>
<thead>
<tr>
<th>Departmental</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Team</td>
<td>Date:</td>
</tr>
<tr>
<td>Board</td>
<td>Date:</td>
</tr>
</tbody>
</table>
Sample Protocol 3: Pupil Dilation Before Diabetic Retinopathy Photography
University of California, Berkeley Optometric Eye Center

Policy
Patients will undergo pharmacological pupillary dilation with one drop per eye of 1% tropicamide solution when retinal images are of insufficient quality for interpretation and no risk factors exist for complications from pupillary dilation.

Background
Approximately 10% of images that are acquired without pupillary dilation with non-mydriatic retinal cameras can not be appropriately interpreted by clinicians due to poor image quality. Two factors that affect image quality are small pupil size and media opacities, such as cataracts. These limitations can be overcome by temporarily increasing the pupil size with pharmacological agents. Better images can be acquired more quickly when pupils are dilated, particularly in older patients, since they are more likely to have small pupils and media opacities. Pharmacological dilation, however, can have adverse effects. The most common adverse effects are photophobia (sensitivity to light) and cycloplegia (inability to change focus, usually causing near blur). Other adverse effects are much less common, and include hypersensitivity, which can cause conjunctival and corneal inflammation and ocular infection from contact with contaminated eye drops. Pupillary dilation has occasionally been reported to cause acute angle closure glaucoma, a painful sight-threatening condition. The use of two dilating agents used in combination for full pupillary dilation have been reported to potentially cause angle closure in approximately one out of five thousand individuals. There have been no reported cases of angle closure caused by using a single dilating agent. One drop per eye of 1% tropicamide can be used as a single agent to provide adequate dilation for retinal photography. Onset of pupillary dilation is approximately 15 minutes and photophobia and cycloplegia will typically last from two to four hours, although rare individuals may experience pupil dilation for up to three days.

Procedure
In the event that adequate images cannot be acquired without pupillary:

1. Photographer or qualified health care personnel determines that patient does not:
   a. have a history of glaucoma
   b. have significant redness, irritation, or discharge from eyes
c. have previously had significant adverse reactions to pupillary dilation
d. is not pregnant
e. is not wearing contact lenses
f. has not had a previous adverse reaction to papillary dilation

2. Explain to patient that one drop will be instilled in each eye to increase pupil size. Blurred vision and light sensitivity may be experienced for two to four hours. Care should be taken when driving or performing other potentially dangerous activities until the effect of the drops goes away. In rare instances the effects may last for two days.

3. The bottle of drops should be discarded if the nozzle appears discolored or contaminated. Do not use expired eye drops.

4. Hold the bottle a half inch to one centimeter from the eye while instilling drop. If simultaneous contact occurs with the drops, the eye and the bottle, then the drops should be discarded due to contamination.

5. Patient can then pat eyes dry with a tissue without vigorously rubbing eyes.

6. Wait between 15 to 30 minutes for drops to take effect.

7. After photography, give the patient plastic sun shields before leaving the clinic in order to avoid light sensitivity.

References
ADA Guidelines on Diabetic Retinopathy Screening.

Approvals
(This area can be changed depending on approvals needed. Signatures are required on all new policies)
Introduction

Teledermatology is the practice of clinical dermatology using the benefits of communication through public or private computer networks. Computer and videoconferencing technologies have the ability to store and rapidly forward both visual and textual data as well as conduct real-time videoconferencing. These technologies allow primary care providers timely access to dermatological expertise for their patients that was previously unavailable.

There are two primary modalities for providing dermatology teleconsultations: store-and-forward and live-interactive (or real-time) teledermatology.

Store and forward teledermatology is the most frequently used mode of computer-based communication between primary providers and dermatologists. A referring provider e-mails an encrypted electronic medical record containing digital images and relevant text data to a dermatologist at a distant site who, in turn, reviews the data and transmits back the requested diagnostic and therapeutic assistance.

Live interactive teledermatology allows the consulting dermatologist to interact and examine the patient at a distant site via videoconferencing equipment. Live interactive teledermatology enables real-time interaction between the dermatologist and the patient. If the primary care provider is present, this modality also allows for dialogues between the primary care provider and the dermatologist. Live interactive teledermatology examinations are generally performed using two cameras: a high-resolution flex-arm camera for overall diagnostic viewing; and a general patient exam video camera (with 50X lens magnification) for closer viewing. Some programs require patient information prior to the live interactive consult, but the dermatologist may also obtain the patient’s history and current concerns during the session. Live interactive sessions are not routinely videotaped. The referral site can capture still shots using the general exam video camera for close viewing; in some instances, the consulting dermatologist may be able to remotely trigger a screen capture to obtain a digital image from the general video exam camera of any view deemed clinically significant.

Teledermatology, whether it be performed using store and forward or live interactive technologies, provides unique benefits for both the patient and the primary care provider by addressing the scarcity of access to dermatologists by rural populations and by delivering point of care education for the non-dermatologist physician, nurse practitioner, or physician’s assistant.

This guide will address the three elements of a successful teledermatology network:

- Hardware
- Software
- Peopleware

The term “Peopleware” was coined by Nancy Lorenzi and Robert Riley in their text on Organizational Aspects of Health Informatics. This means that managers in institutional clinics or primary practitioners in private settings need to truly support the effort to incorporate telemedicine into their overall healthcare delivery efforts.

The information subsequently presented is to be understood as a guide. Various providers, as well as healthcare facilities, often develop their own style of practice. However, as long as all individuals involved in the telemedicine network follow some basic procedures unique to clinical dermatology, store and forward and/or live interactive teledermatology become powerful tools that allow dermatologists to assist primary care providers in delivering quality care for patients who would otherwise have no access to evaluation by a dermatologist.
Store and Forward Teledermatology

The model to be described in this guide has been used to successfully conduct store and forward teledermatology consultations for over 7 years, representing more than two thousand consultations performed as part of the Anthem Blue Cross of California Telemedicine Program. When all of the practice elements are followed, this model offers a very economical approach to providing enhanced specialty access, thereby improving the quality of skin care for the patient. In fact, based on the frequency with which the dermatologist needs to change the provisional diagnosis and associated therapy (60 – 80% of cases), the quality of care is significantly enhanced, as would be expected by providing specialist participation.

The “Open Access Model” (OAM), as it will be referred to, allows multiple referral as well as specialist sites to interact with each other. This model differs from the more traditional hub and spoke model that employs a central specialist (hub) site to which are connected multiple referral (spoke) sites. The basic OAM unit consists of a referral site, a consult site, and the linkage that allows the two sites to electronically communicate.

Referral Site

An effective store and forward teledermatology consult requires that the referral site provide enough information for the consulting dermatologist to offer effective diagnostic and therapeutic assistance. Because the dermatologist cannot directly interview and examine the patient, the challenge for the referral site is to provide: 1) the verbal information that dermatologists get from their patients before doing a visual assessment, and 2) the visual assessment of the actual skin lesions. The referral site supplies two data elements: 1) focused text, and 2) appropriate images.

1. Focused Text

A common misconception is that a dermatologist can diagnose any skin disease from a picture. In fact, the dermatologist often relies on verbal data (e.g. clinical history, previous therapies and their results, previous laboratory studies, concurrent illnesses, etc.) to provide critical guidance in interpreting visual information and in making therapeutic recommendations. When this selective verbal data (i.e., focused text) is combined with appropriate clinical images, a choice of possible diagnoses suggested by visual data alone can be narrowed to a specific diagnosis or the information may help identify what further testing or procedures may be needed.

The importance of focused text can be illustrated in the following example:

A referral was e-mailed to a dermatologist for evaluation and management suggestions. The referring provider stated the skin problem did not respond to topical anti fungal therapy. The dermatologist however, felt that the images were, in fact, most compatible with a fungal infection. However, he assumed that the reported failure of anti fungal therapy ruled out this diagnosis. The dermatologist provided a differential diagnosis (i.e., what other skin diseases needed to be considered that could look like a fungus infection). A biopsy was suggested by the dermatologist. Examination of the biopsy subsequently documented a fungal infection.

If this patient had a fungal infection to begin with, why was there no response to the anti fungal medication? What possible information could have prevented an unnecessary biopsy? The answer to both questions lay in the referring provider’s documenting for how long the anti fungal medication was applied; he or she assumed, as did the dermatologist, that the medication was properly used.
Had the provider inquired, he would have found out that the patient stopped the medication after 1 week because he didn’t notice much response. In fact, 4 – 6 weeks of therapy would be necessary to eradicate the fungal infection. This type of outcome underscores the importance of documenting patient compliance with previous therapy. Consequently, the dose and length of time a patient uses any medication for a skin condition should be part of the focused text in a teledermatology referral. Similar experiences have taught the dermatologist what information, in addition to images, is most important for evaluating the majority of skin diseases.

A “Skin Evaluation Form” (see section on a sample store and forward referral and consult) is designed to assist the non-dermatologist provider in regard to what questions to ask a patient who presents with a skin complaint. This 1-page form contains 11 questions related to the patient’s skin problem that help dermatologists make a diagnosis and suggest appropriate therapy. It can be filled out by the patient or used as a guide by the referring provider. The completed form can also be scanned or digitally photographed and included in the e-mailed referral.

2. Appropriate Images
When a dermatologist examines a patient in person, he or she assesses three characteristics of any skin lesions: 1) their location, 2) their size, and 3) their surface features (e.g., are they flat (i.e. macular) or raised (i.e. papular of nodular), flesh-colored, pink, or pigmented, lighter or darker than the normal skin, etc.); in addition, the dermatologist may feel the lesion(s) for consistency. Therefore, the digital images captured for a skin problem should at least be able to convey the location of the lesions, their size, and their surface features. The consistency of a lesion (e.g., firm, soft, rough, greasy, not palpable, etc.) can be described in the referral note to the consultant.

It must be understood that an image that is out of focus is of no use to the dermatologist and could also be of medical-legal consequence. Therefore, no image should be incorporated into a teledermatology referral unless it has been previewed and the focus is sharp. This may appear as self-evident but the number one problem encountered in doing a teleconsult. The main cause of this is that the photographer does not review the images before placing them in the electronic referral. Telemedicine technicians using very good digital cameras assume an auto-focus camera will provide in-focus images and fail to review each image; this is an unacceptable approach because no camera is fail-safe, especially since autofocus actually can involve different settings that require different positioning of the site to be digitally captured.

In regard to close up images, these need to provide some idea of the size of the skin lesion, as well as the location especially if there are no recognizable anatomic markers within the picture field (e.g. the nose, ear, finger or eye). Referrals are often sent where the size and location of a lesion are not provided. For the dermatologist, the size and location of a lesion can be critical. Please refer to Appendix B at the end of this guide that addresses optimizing images for store and forward teledermatology.

Consultant Site
A teledermatologist should be expected to: 1) identify the skin problem or indicate what needs to be done (e.g., a biopsy or laboratory test) in order to provide a specific diagnosis, 2) offer therapeutic guidance in treating the skin problem, and 3) provide a follow-up framework to insure that the patient is appropriately responding to therapy. In addition, recommendation may be made for an in-person consultation in particularly complex skin problems.
Communication between Referring and Consultant Sites

How the referring and consulting sites communicate is critical to a functional store and forward teledermatology network. For sustainability, it should be economical, efficient, secure, and reliable so as to provide the participants at each end with an easily accessible electronic record of every patient encounter. To date, the most economical, efficient, and reliable way to communicate is the internet. HIPAA-level security can be provided by encryption of data before the information is sent over the internet. Each site in the store and forward teledermatology network in which this author participates uses the same commercially available software program to create their electronic consult referrals. For each patient, the software creates an electronic folder containing a demographics form, referral form, and image viewer. The referring group fills in these electronic forms, imports the accompanying clinical images, and then sends the patient’s electronic record to the dermatologist as an e-mail attachment. The consulting dermatologist will find the referral in his or her e-mail box, download the attachment to their computer “desk top” or into a previously created “new patient” folder. Opening the attachment will automatically launch the software on the consultant’s computer so the patient file can be viewed. The consultant then enters his or her diagnostic opinion and therapeutic recommendations in a consult form that is then e-mailed back to the referring site as an encrypted attachment.

When opened by the referring group, the consult is automatically transferred to the appropriate patient’s referral file. Now both sites have copies of the complete patient file.

Each participating health care facility has a dedicated computer that is linked, ideally with a broadband connection for fast uploading and downloading, to the Internet. But if necessary, even a modem connection can work; uploading and downloading just require more time.

A major advantage of this system is that it is adaptable to each user, as well as portable. A laptop or desktop computer can be used. A network can consist of federal, state, and community-supported clinics and hospitals, as well as private group practices – each with their own specific operational needs. From the teledermatology consultant’s point of view, none of these differences matter because the software presents the same user interface (i.e., visual format) for all electronic referrals while allowing each referring site to enter any unique information they require within this consistent format. In addition, a billing application is available that allows a standard 1500 form to be created and maintained in each patient’s folder so that reimbursement issues can be handled and maintained within each patient’s electronic record, both at the referral and consultant sites.

Another platform available for store and forward teledermatology is the use of a secure website that hosts the electronic medical record. Rather than the referring and consulting providers having all the records on their own computers through the use of common software, they all connect to a secure website that hosts the record system. Gaining access through a specific user name and password, the referral text and image data is uploaded to the website record which can then be viewed by the consulting dermatologist who in turn enters his or her diagnoses and/or therapeutic recommendations. These websites may automatically notify the appropriate provider by email when a referral has been submitted or a consult completed. Which platform to use, computer-based software or secure website, will often depend on the needs of individual groups or institutions. For example, some institutions do not want any patient data stored outside their facility so they may want to use a software-based system.
and keep all data on site. On the other hand, some practitioners may favor having a secure website that may free them from concerns about upgrades and maintenance of a software-based system. Ultimately, both platforms, if made user-friendly, can provide the appropriate connectivity to do effective teleconsultations where the referring and consulting providers have the freedom to integrate telemedicine into their own workflow in the most convenient way.

**Helpful Tools**

Although a wide variety of equipment and peripherals may be employed as part of a telemedicine program, the majority of store and forward teledermatology programs rely principally on the use of digital still cameras to produce images for clinical diagnosis and consultation, and various software designs or secure telemedicine websites to store, catalog, and/or transmit those images. The Telemedicine Information Exchange (TIE) is a National Library of Medicine-funded web site (http://tie.telemed.org/vendors/) which offers comprehensive information on telehealth vendors and can be used as a resource for identifying and comparing products related to store and forward telemedicine systems.

**Cameras**

Photography of skin problems has long been an established tool for diagnosis and record keeping among dermatologists. In recent years, the success of teledermatology has been greatly facilitated by the continuing reduction in cost and increase in quality of digital cameras. Currently, a wide variety of digital still cameras are available that may be suitable for Teledermatology use, depending on the specific needs of the program and its practice guidelines. Commercial digital cameras are available as fixed lens, autofocus point and shoot (PAS) or digital single lens reflex (DSLR) systems.

The minimal features that a digital camera should have in order to capture optimum images for teledermatology are: 1) at least a 1.3 megapixel image size, and 2) a macro setting for close-up images. Ideally, images should be acquired without flash using natural (window light). It is no longer necessary to have a $1000+ digital camera to capture adequate clinical photos. A more-than sufficient camera can now be purchased in the $300 - $500 range. A number of reputable manufacturers make cameras that are suitable for teledermatology.

In addition to these commercial digital still cameras, examination cameras have been developed specifically for telemedicine applications in that they are able to interface with a wide variety of peripherals and communications systems; accordingly these cameras are significantly more costly ($4000 - $6000 range).

Although it is essential to carefully select camera equipment suitable for clinical application, it is also important to keep in mind that the major problem this author has encountered with digital images sent for evaluation, whether the camera cost $300 or $5000, is a lack of focus; this problem is more a consequence of the know-how of the photographer. Any teledermatology referral site coordinator responsible for taking patient images should know the details of operating their digital camera just like a radiology technician knows the details of how to properly acquire an MRI or CT scan. It is essential to develop standardized policies and procedures to reproducibly provide sharp images where the photographer or referring provider can say “I can clearly see what I want the consultant to see”.

**Computer-based Software**

Depending on the scope of the teledermatology program, software needs may vary from a simple means of file encryption coupled with an off-the-shelf e-mail system to a full suite of Picture Archiving
and Communication System (PACS) software. Somewhere in the middle of these extremes there exists a number of quality software solutions designed with teledermatology in mind, which easily facilitate image handling, cataloging, transmission, and even the appendage of associated notes for inclusion in an electronic health record system. Although this author and CTRC do not endorse specific vendors or products, they would like to offer sincere appreciation to Second Opinion Software (www.2opinion.com) for the use of screen captures from their product to illustrate examples within this guide. A number of image management solutions exist for teledermatology (refer to Vendors on TIE website). There is also the option, as previously cited, of commercial telemedicine websites that provide a secure online electronic medical record that can be utilized by medical networks wanting to provide a platform for doing store and forward teledermatology; in this case, all that is needed is a computer with high speed (e.g. DSL) access to the internet.

Ultimately, as stated in the introduction, it is the “peopleware” that are the key to the success of a teledermatology network.

**Checklist for Store and Forward Teledermatology**

1. **Site Coordinator:**
   A teledermatology site coordinator at the referral site. These individuals can be either physicians, nurse practitioners, or physicians’ assistants totally competent in computer-based communication and digital camera operation. In the case of a private practice or group practice, it is possible for the consulting physician to function as the coordinator since computer programs for managing medical records, as well as claim generation, exist to minimize support staff and lower the cost of operation.

2. **Connectivity:**
   High speed DSL internet access for all sites participating in the telemedicine network.

3. **Computer Hardware:**
   Dedicated laptop or desktop computers that either share the same electronic medical record system (128 bit encryption to satisfy HIPAA rules about privacy) or can connect to an internet VPN server site that hosts the electronic medical record system. Both platforms can be simultaneously handled by the same computer.

4. **Data Back-up Hardware:**
   A convenient storage system for backing up all medical and claims records generated (e.g. external hard drive).

5. **Digital Camera:**
   Each referral site needs a 1.3 – 5 megapixel (MP) digital camera with macro imaging capability. Newer single lens reflex digital cameras (around $600) offer the benefit of being able to directly see through the lens system that the image is in focus before closing the shutter. This is an advantage over the point-and-shoot auto-focus systems where lack of focus at the point of interest is frequently a problem due to the properties of auto-focus systems.

6. **Consent:**
   Every teledermatology patient needs to be informed and verbally consent to participate in a store and forward service.
7. Operational Standards:
Both the referral site and consulting site should have in place operational standards that meet the legal standards of the area as far as operating a medical clinic or office.

8. Maintenance of Telemedicine System:
If there is a centralized IT unit responsible for operation and maintenance of the telemedicine system, both users and IT personnel need to know the parameters of operation of the system (e.g. file size range for firewall settings, back up and retrieval systems for relevant records etc.).

Sample Store and Forward Referral and Consult

Descriptions of processes like store and forward consults can sometimes be intimidating because of all the words needed to describe the process. Sometimes, the best way to convey the process in a less intimidating way is to provide an example. What follows is a sample case that will tie in all of the elements discussed above in an optimal store and forward teledermatology consult. What the reader will see is the user interface of the Second Opinion System, but the same data could be presented in another format as long as it includes the data elements that allow the consultant to 1) Provide a diagnosis or necessary diagnostic work up, 2) Recommend therapy, and 3) Have the data necessary to submit a claim for reimbursement.

The following sections include a sample demographics form, a referral form, and images that would make up a referral, as well as a consult form that would be returned to the referring provider. In addition, a sample of a CMS 1500 billing form with the sections highlighted that most third party payers require for reimbursement of services can be found in Appendix C. The reason for including this reimbursement form is that in a busy network, if the required billing data isn’t provided with the initial consult, literally hours of time can be wasted trying to track down this information, especially when dealing with multiple sites and multiple insurance groups.

User Interface of an Electronic Referral
Access to the electronic medical record requires a registered user name and password entry. Clicking on the encrypted email attachment (patient file) opens the Document Manager and the selected patient record appears on the computer desktop. The data elements include: 1) Demographic information, 2) Referral form, 3) Optional Skin evaluation Form, and 4) Image Thumbnails.

* Images reproduced with permission from Second Opinion Software, LLC, Torrance, CA
Open Demographics Folder
Note the three tabs on the upper left of the form: Identification, Address, and Reference; clicking on each tab opens the required form (see below). This information is necessary for billing.

Address Information Page
Reference Information Page
This is used for identifying the primary provider and also for billing.

Open Referral Folder
Note again 3 tabs for 1) Clinical Information, 2) Referral Information, and 3) Specific Questions. Notice the field for entering the Provisional Diagnosis.
Clinical Information Page

The Relevant History should provide the following information for each skin problem: 1) How long it has been present, 2) a list of symptoms if any, as well as noting a lack of symptoms, 3) previous skin medications including vehicles for topical agents (i.e. ointment, cream, lotion, gel), strength of topical agents (i.e. 0.1%, 2% etc.), and their names (e.g. triamcinolone), 4) outcomes of therapy (e.g. better, same, worse), 5) oral medication including type, strength, dose, length of time used and clinical outcomes.

Under relevant physical findings, remember pictures have been provided so that descriptions can be minimized except for describing the feel of a particular lesion (e.g. soft, firm, fluctuant etc.).
Specific Questions Page
This is where the referring provider or patient (in this case) may enter questions they would like answered.
Sample Skin Evaluation Form

This is where Skin Evaluation Form that the referring provider fills out and scans into the patient’s electronic file or may use as a guide to fill in the relevant clinical history.

SKIN EVALUATION FORM

1. Name: ________________________________________    2. Date: ___/___/_____
   Last                               First                   Middle
6. Skin problem has been present (Check one):
   Less than: 1 week: ☐   1 month: ☐   6 months: ☐   1 year: ☐
   More than: 1 year: ☐   5 years: ☐   10 years: ☐
7. How does skin problem bother you? (Check all that apply):
   Appearance: ☐   Itching: ☐   Bleeding: ☐   Burning: ☐   Aching: ☐   Throbbing: ☐
   Growing bigger: ☐   Getting darker: ☐   Getting lighter ☐
8. Skin Medications (please list name, concentration, type (cream, ointment, etc) and how long used:
   1. ___________________________________2. __________________________________
   3. ___________________________________ (use back of sheet if necessary)
9. Oral Medications (please list name, dose, how often taken and for how long):
   1. __________________2. _______________________ 3.  _____________________
   (use back of sheet if necessary).
10. Do you or your parents have a history of skin cancer or melanoma?: Yes ☐ No ☐
11. Please indicate on the body maps below the location(s) of skin problems(s)
Image Viewer
Clicking on a thumbnail image will open the image viewer and show an enlarged image of the selected thumbnail. It can be further enlarged, tiled with another image or images for comparison, and or annotated with arrows or circles to indicate points of interest or sites to biopsy.

Consult Folder
In the Consultation field is where the teledermatologist enters the diagnosis and any explanatory text he or she feels is appropriate. This may include suggestions for a confirmatory biopsy or other laboratory tests to help clarify an equivocal diagnosis. The recommended treatment plan and follow up recommendations are also entered. This particular software program contains a function for converting this text into a letter-style format if a printed version is requested. The consult folder can then be sent, via an automatically encrypted email attachment, to the referral site.
Best Practice Model: Live Interactive Teledermatology

The live-interactive (LI) teledermatology model described in this guide has been employed for over 12 years at the University of California Davis (UCD). Since 1997, dermatologists from UCD have completed over 7,700 live interactive teledermatology visits to Californians. This live interactive telemedicine model has also been adapted for use in other specialties, including psychiatry, infectious disease, pediatrics, endocrinology, and gastroenterology. Since 1992, the telemedicine program as a whole at UCD has provided over 15,000 video-based clinical consultations to 80 clinic and hospital sites in California in 30 medical specialties and subspecialties.

The live interactive model is based on the “Hub and Spoke Model”, where a specialist can be connected with multiple referral (Spoke) sites. For example, for any given live interactive teledermatology clinic, the dermatologist may be connected with up to 5 different sites. While this model requires scheduling effort, it allows referral sites with low patient volume to have immediate access to teledermatologists through real-time teledermatology.

Referral Site

The requirement for an effective referral site for live interactive teledermatology is different from that of store and forward teledermatology. This is based to the fact that the dermatologist is able to communicate with the patient, the teledermatology coordinator, and/or the primary care provider in real-time to obtain information that may not be present on the referral form. While referral forms are still necessary to obtain basic clinical information, such as reasons for referral, allergies, and medications, the emphasis for live interactive teledermatology is ensuring an efficient operational flow of conducting real-time visits that maximizes patient and provider satisfaction and clinical outcome. In the following sections, we will discuss important operational considerations from the referral site during live interactive teledermatology consultations as well as how to capture appropriate images useful for diagnosis and providing treatment recommendations.

Operational Considerations

Similar to face-to-face visits, patients must be scheduled to see the teledermatology coordinator and the dermatologist for live interactive teledermatology consultations. Therefore, live interactive teledermatology is sometimes referred to as “synchronized teledermatology.” Live interactive teledermatology is conducted over videoconferencing, with at least a teledermatology coordinator at the originating site to present the patient. The presence of the patient’s primary care provider during the consultation is optional depending on the preference of the referral sites, and frequently a well-trained teledermatology coordinator alone is adequate to conduct the live interactive visits.

From the perspective of the referral sites, four aspects of the operation are important to complete a successful live interactive teledermatology encounter: (1) communication with patients, (2) time management, (3) camera operation, and (4) patient positioning. Referral sites’ communication with the dermatologist is discussed separately in another section below.

For patients new to live interactive teledermatology consultations, the coordinator needs to introduce the dermatologist to the patient, the equipment setup, and the interactive nature of the encounter. This introduction helps orient the patient to the live interactive teledermatology environment at the beginning of the visit. Most patients become quite comfortable with this model of care-delivery after the first few minutes.
Because patients are scheduled sequentially for live interactive teledermatology visits, to ensure that each patient is seen in a timely manner, time management is central for successful live interactive teledermatology visits. Good time management requires concerted efforts from the teledermatology coordinator as well as the dermatologist. An experienced coordinator begins each session by turning on and testing the videoconferencing equipment before patients arrive. The coordinator can also quickly review the patient’s referral form to identify body areas that will need to be uncovered for examination. The coordinator will need to actively communicate with the patient to help the patient focus on the dermatologic problem of interest, relevant review of systems, and addressing the patient’s concerns.

The teledermatology coordinator at the originating sites must be well-trained on operating the dermatology camera. The training sessions need to occur before the new coordinator is involved in actual patient care to avoid unnecessary delays during the live sessions, and the coordinator needs to demonstrate competency with camera operation before their first clinic. The coordinator should always wear gloves to maintain cleanliness of the camera during the live interactive sessions and change gloves in between patients. If the camera has a probe, it is important to place a thermometer condom on the probe during patient examination and change the thermometer condom in between patients. The coordinator needs to be intimately familiar with the main operational buttons on the camera, and he or she needs to be facile at switching between scanning and capturing freeze frames.

Correct patient positioning allows the teledermatology coordinator to capture quality images and makes teledermatology visits more efficient. If the dermatology camera does not contain an image viewer on the camera itself, it is important to position the patient in between the dermatology camera and the videoconference monitor in one line of sight such that the coordinator can easily see whether an image is captured correctly on the video monitor. It is important to explain to the patient that, while the providers will take every measure to respect the patient’s modesty, it is also important to obtain adequate exposure of the body areas to be examined. Therefore, it may be necessary to alter the patient’s body positioning several times, such as changing from a sitting to a laying down position, in order to adequately examine areas such as skin folds. When the dermatologists requests examination of hand or feet, the coordinator will have the patient spread out their fingers and toes so that the dermatologist can examine the web spaces adequately.

**Appropriate Images**

Live interactive teledermatology differs from store and forward teledermatology in that real-time communication between the consultant and the teledermatology coordinator allows adjustment of image quality and retaking of images if necessary during the visit. However, the basic characteristics of skin lesions that a consultant must be able to assess are the same as those in store and forward teledermatology: location, size, and surface features.

The image quality can vary significantly depending on the connection speed, operational experience of the teledermatology coordinator, camera resolution, and whether freeze frame is used. In this section, we offer several general tips on how to capture the best-quality images regardless of the type of videoconference system or connection speed used. In the “Helpful Tools” section, we will discuss specific videoconference equipment and connection considerations.

First, the exam room where live interactive teledermatology sessions take place must have adequate lighting. This is because the illumination device that accompanies most skin exam cameras does not usually provide sufficient illumination by itself. Second, it is preferable that the teledermatology coordinator wears blue, sometimes called “telemedicine blue”. It is not recommended that the coordinator wear bright colors or wild prints because these colors are not only distracting but also may alter the skin color.
As the coordinator moves the skin examination camera, he or she needs to continuously verbalize the part of the body that is being captured. This helps to orient the dermatologist to the location of the lesions. When the dermatologist encounters a lesion of particular interest, the dermatologist can ask for a ruler to be placed next to the lesion in order to measure the size of the lesion. The dermatologist should also ask for a freeze frame of the skin lesion. Freeze frames are critical to visualizing the skin lesions, especially in the setting of slow connection speeds. Freeze frames allow the dermatologist to appreciate fine surface features of the skin lesions and minimize much of the image degradation that occurs with scanning with the camera.

Having an experienced telemedicine coordinator is critical to capturing high-quality images during live interactive teledermatology sessions. Inexperienced coordinators may move the skin exam camera wildly in different directions, scan the body areas with inappropriate speed that compromises image quality, or worse, fail to show the dermatologist relevant skin lesions. In some instances, if an inexperienced coordinator at the referring site scans body regions aimlessly and fast, the coordinator may even cause the consultant dermatologist to feel motion sickness. Therefore, proper training and demonstration of competency for all live interactive teledermatology coordinators are important before initiation with actual patient care.

**Consultant Site**
What is expected of a dermatologist during a live interactive teledermatology consult is quite different from that of Store and Forward consults. Because real-time interaction occurs among the dermatologist, patient, teledermatology coordinator, and sometimes the primary care provider, the dermatologist is expected to (1) communicate with all the parties involved throughout the encounter, (2) make diagnosis, (3) provide treatment recommendations, (4) explain the diagnosis and recommendations in understandable terms to the patient and/or primary care provider, and (5) keeping up the clinic schedule. This can be especially challenging if the encounter time is limited or the images are suboptimal.
Communication and Connection between Referring and Consultant Sites

Due to the interactive nature of real-time teledermatology, communication between the referring and consultation sites is critical to a successful encounter. While it is preferred that one person speaks at a time during a visit, in practice, it is not uncommon that two or more individuals speak simultaneously. This is because, in addition to the usual challenges of human conversation, communication in live interactive teledermatology is further complicated by potential, slight delay in sound transmission with the videoconference technology. Therefore, it is important that the coordinator and the consultant understand one another’s communication style and strive to adjust their communication for optimal patient care and clinic efficiency.

Improved communication between the referring and consultation sites can lead to greater diagnostic accuracy. The teledermatology coordinators help the consultant achieve greater diagnostic accuracy not only by identifying lesions of interest and capture them with high image quality; they also function as the dermatologist’s hands and report tactile information to the dermatologist. That is, because the dermatologist is unable to appreciate the tactile qualities of a lesion, such as firmness, softness, and mobility, the dermatologist depends entirely on the coordinator to relay that information.

From a technology perspective, communication through the videoconference units between the referring and consultant sites occurs via secure, dedicated connections. While videoconferencing equipment information is presented in the “Helpful Tools” section, the discussion here will focus on the connection types between the referring and consultant sites.

Because live interactive teledermatology is usually performed among sites that are geographically distant, communication occurs through Wide Area Network (WAN). Many WAN technologies are available today, and the most common ones include Plain Old Telephone Service (POTS), Digital Subscriber Line (DSL), Cable, Integrated Services Digital Network (ISDN), and T1 connections. In telemedicine, video and audio information are most commonly transmitted via one of the following two protocols: ISDN protocol or Internet Protocol (IP).

Although ISDN did not achieve ubiquity, ISDN was introduced in the mid-1980s to update the existing telephone system to digital telephone. Because ISDN was a pioneer in broadband Internet access and afforded the necessary security, it became ideal for live interactive telemedicine applications. Although ISDN may now be considered outdated by some, the majority of live interactive telemedicine activities are still performed over ISDN today.

There are two types of ISDN: Basic Rate Interface (BRI) and Primary Rate Interface (PRI). The BRI is commonly used for site-to-site connections, and it requires 3 BRI lines (at 128 kbps per BRI line) to achieve a 384 kbps connection—the minimum bandwidth necessary for live interactive teledermatology videoconferencing. In comparison, PRI has a maximum bandwidth of 1.5 mbps, which is nearly equivalent to 12 BRIs and capable of connecting multiple videoconference calls at once. PRI can also be used to deliver high definition video that require high bandwidth signals. Because ISDN is essentially a digital telephone line, the ISDN number appears as a telephone number, such as (123) 456-7890.

In contrast to ISDN, Internet Protocol (IP) uses the internet to transmit video and audio information in telemedicine instead of a digital telephone connection. IP has several advantages compared to ISDN. These advantages include the ability to leverage infrastructure, improved reliability, enhanced
manageability, installation simplicity, expanded scalability, predictable usage fees, call speed flexibility, and enhanced security.

The majority of live interactive teledermatology programs that changed from ISDN to IP in the recent years use T1 connection to transmit IP information. One T1 line provides high-speed connection at 1.5 mbps. A T1 line affords dedicated service where only two ends of a connection can communicate with each other; therefore, additional T1 lines must be purchased for additional sites. Because most site-to-site connections will not require the use of a full T1 line, sites can arrange to purchase a fraction of a line for at lower cost. Although IP information can be transmitted over other broadband services such as DSL, Cable, or fiber optics, these connections typically occur through shared and non-secure networks and therefore are not suitable for telemedicine activities without additional configurations to achieve HIPAA compliance.

Policies and Procedures
Policies governing store and forward and Live Interactive teledermatology involve two federally mandated principles applied to clinical practice in general: 1) safeguarding patient privacy (based on HIPAA regulations) and 2) obtaining patient consent prior to a teleconsultation.

Each of these policies translates into procedures that insure mandated policies are upheld.

1) Ensuring Patient Privacy: Since computer and videoconference units are the vehicles through which store and forward and live interactive teledermatology is conducted, HIPAA rules require appropriate protection of such communications over the internet. In store and forward teledermatology, the most straightforward approach to achieving this is through the use of a software application that automatically encrypts the data to be shared (HIPAA currently requires 128 bit encryption) so that only those network participants who have the ability to decode the information can view it. In live interactive teledermatology, secure connections between the referring and consultants sites are established via dedicated internet protocol or ISDN lines that safeguard the privacy of the connection.

Helpful Tools
The information below purports to serve as a resource for the readers to become familiar the range of videoconference products available for live interactive teledermatology. The authors do not endorse particular products for live interactive teledermatology.

The American Telemedicine Association provides an unbiased Buyer’s Guide that serves as a useful resource for product comparison.

The Teledermatology Special Interest Group of the American Telemedicine Association has also published practice guidelines for standards and recommendations for best practices for live interactive and store and forward teledermatology. These practice guidelines can be found at http://media.americantelemed.org/ICOT/Standards/Telederm_guidelines_v10final.pdf.
Video Conferencing Equipment
In North America, Tandberg, Polycom, or Life Size are the three major vendors of video conferencing equipment. To conduct live interactive teledermatology, the requirements for video conferencing equipment should include the following:

- H.264 video compression standard or better
- H.323 compliant
- H.261 video compression standard compatibility
- G.711 audio compression standard or better
- Live Video resolution 4CIF (704x480) or higher
- Content resolution XGA (1024x768) or higher
- Capable of connecting at 384kbps running 4CIF @ 30fps

It would be prudent to avoid purchasing proprietary components such as power, audio inputs and outputs that can only be used for a specific make and/or model.

The cost of video conferencing equipment can vary widely depending on the model and added features. For live interactive teledermatology consults, one unit of video conferencing equipment can range from $10,000 to $15,000.

Video-Format General Examination Cameras
Video-format general examination cameras are peripherals attached to the videoconferencing units that allow for close-up examination of skin lesions. These cameras typically have the ability to scan, zoom, auto focus, and freeze-frame capture the skin lesions; some cameras are also equipped with electronic image polarization. It is important that these cameras have an internal lighting source to help illuminate the skin lesions if the ambient lighting is suboptimal.

Currently, the two major types of video-format general examination cameras used in live interactive teledermatology are consumer-grade camcorders (either standard definition or high-definition) and the AMD-2500 general examination camera. The newer models of consumer-grade camcorders available in the U.S. market deliver high-quality video images with as much versatility as video cameras designed for telemedicine practice. The only drawback of the consumer grade camcorders is that most of them lack image polarization feature, which could be helpful in certain instances.

Checklist for Live interactive Teledermatology
1. Referral-Site Telemedicine Coordinator:
   A telemedicine site coordinator is necessary at the referral site. This individual can be a physician, nurse practitioner, physician’s assistant, or medical assistant. It is important that the coordinator is trained in operating the videoconferencing and general exam camera equipment. Because any motion in the hands can severely degrade the quality of the video images, the coordinator needs to be able to hold the camera steady to capture good quality images.

2. Connectivity:
   A T1 line affords dedicated service where only two ends of a connection can communicate with each other. One T1 line provides high-speed connection at 1.5 mbps. If the teledermatologist performs consultations with more than one referral site, additional T1 lines will need to be purchased for additional sites. However, because most site-to-site connection will not require the use of a full T1 line, sites can arrange to purchase a fraction of a line for at lower cost.

3. Videoconference Hardware:
   As stated above, to conduct live interactive teledermatology, it is important to check the
videoconference equipment specifications to ensure that they meet the requirements for conducting telemedicine consultations (specifications are listed in the above section). Videoconference units that meet the specifications for telemedicine cost on average $10,000 to $15,000 per unit. Each site must be equipped with a videoconference unit.

4. Video-Format General Examination Camera
   As discussed above, video-format general examination cameras have the ability to scan, zoom, auto focus, and freeze-frame capture the skin lesions. The referral site can purchase either telemedicine-specific video-format general examination camera or consumer-grade camcorders. The cost of consumer-grade camcorders sufficient for live interactive teledermatology consultations ranges between $600 to $1,800, whereas the cost of telemedicine-specific video-cameras typically ranges between $5,000 to $6,000.

5. Consent:
   Every telemedicine patient needs to be informed and provide verbal consent acknowledging their understanding of, and willingness to participate in, a live interaction teledermatology consult.

6. Operational Standards:
   Both the referral site and consulting site need to have in place operational standards that meet the legal standards of the area as far as operating a medical clinic or office.

7. Technical Support:
   The purchase of the videoconference equipment is often accompanied by bundled technical support packages from the manufacturer. Having the technical support service from the manufacturer is generally highly recommended for a real-time teledermatology operation because interruptions in the system can lead to frustrating encounters and patient rescheduling. It is more desirable if the healthcare organization is able to provide additional Information Technology support.

Summary

Store-and-Forward Teledermatology

With off-the-shelf computer equipment, a commercially available 1.3 to 3 megapixel digital still camera, either software that provides a 128-bit encrypted electronic medical record, high-speed Internet access, or access to a secure website hosting a teledermatology communications program, and most importantly, trained individuals (Telemedicine Site Coordinators) comfortable with this technology, a store and forward teledermatology referral site can be created. The consultant (ideally board certified in his or her given specialty) only needs a desk or laptop computer, high-speed Internet access, the same software or secure website as has the referral site, and he or she is ready to provide consultation services to the referral site.

The elements constituting an appropriate teledermatology store and forward referral include:

- A signed patient consent form in the patient’s referral site record;
- Focused text on the patient that addresses both the clinical skin problem (based on a Skin Evaluation Form), as well as billing information required for reimbursement of services; and
- Digital images of the patient’s skin problem that convey: 1) location of the skin problem(s), 2) size of skin lesions, and 3) surface features (details of characteristic lesions).
This electronic record is then automatically encrypted by the software and can be sent as an e-mail attachment to the consultant or the data can be entered online at a secure website which notifies the consultant by e-mail of a pending referral.

The elements that make up an appropriate teledermatology store and forward consult include:

- A clinical diagnosis for each of the referred skin problem(s) if possible
- A differential diagnosis if a single diagnosis is not possible with the data provided, and what tests or procedures may be required to arrive at a specific diagnosis;
- Therapeutic recommendations for each diagnosis provided;
- A recommendation for follow-up to assess therapeutic efficacy and clinical response; and
- A contact number for the consultant that will allow the referring providers or patients to contact the specialist if any questions arise.

This electronic consult is then returned to the referral site as an e-mail attachment or after the consult is entered into a secure website system, the referral site is notified by e-mail of the finished consult.

**Live Interactive Teledermatology**

Using videoconferencing equipment, live interactive teledermatology increases patient access to dermatologic care while preserving consultant-patient interactions. The main advantage of live interactive teledermatology is that this model of healthcare delivery closely mimics office-based interactions and allows dialogue exchange between the specialist, the patient, and sometimes the referring provider. The set-up and maintenance cost for live interactive teledermatology is considerably higher than that of store and forward teledermatology due to the higher cost of videoconferencing equipment, video-format general examination cameras, and connection charges.

Because the interaction between the referral and consultant sites is synchronized and real-time dialogue takes place during the encounters, the elements that make up a successful live interactive teledermatology encounter include the following:

- Orientation of the patient to the live interactive teledermatology environment
- An experienced teledermatology coordinator familiar with operating the videoconferencing and general examination camera.
- Connection speed of at least 384 kbps between the referral and consultant sites (The connection speed has profound impact on the quality of transmitted images.)
- Focused dermatologic problems. (In the author’s opinion, total body skin examinations are time-consuming and often yield poor scanning images; thus, they are not necessarily suitable for live interactive teledermatology encounters.)
- Dermatologist able to communicate effectively and efficiently with the patient, the teledermatology coordinator, and the referring provider.

Live interactive teledermatology can be a very rewarding process for the patient, the teledermatology coordinator, the referring physician, and the dermatologist. The involved parties often feel that they are working in concert and have engaging dialogues regarding the patient’s skin disease. The dermatologist can often use this opportunity to educate the patient as well as the referring physician on the skin disease.
Optimizing Images
Images sent to a dermatology teleconsultant must provide the following visual information for skin problems: 1) location(s), 2) size, and 3) surface features.

1. LOCATION: A picture must allow the consultant to identify the anatomic part(s) where the skin problem exists (Figs. A & B). If the whole body is involved, capture front, side and back views.

2. SIZE: If there is a single skin lesion, use an adhesive millimeter tape or ruler placed near the lesion that will give the consultant an idea of the size of a given lesion (Figs C & D).

If multiple lesions exist, place an adhesive rule within the picture field as a guide to lesion sizes (Fig. E).
E. Digital photo of several moles with a millimeter tape to provide a reference for size.

3. SURFACE FEATURES: Use your cameras macro capability to take a picture as close up as possible while keeping the whole lesion within the picture field (Fig. F).

F.

Use a raking light or window light from the side that will, by casting slight shadow, reveal elevation or texture of a skin lesion. (Figs. G & H).
G. A skin cancer with poorly defined borders captured under overhead light

H. Same lesion stands out more when raking light is used (light source coming from right side.)
SAMPLE LIVE-INTERACTIVE CONSULT

Dear Dr. Johnson,

I had the pleasure of seeing Ms. Smith in our Telemedicine Clinic at UC Davis in consultation at your request for evaluation and management of a lesion on the forehead. Ms. Smith reports having had this lesion on the left upper aspect of her forehead for approximately 5 years, and it is slowly enlarging. She reports that this bleeds spontaneously at times, and it is tender to touch. She has not received any treatment to this lesion. Ms. Smith had moderate sun exposure as a child and 3 blistering sunburns that she can recall. She does not use sunscreen regularly.

Past Medical History: Gastroesophageal reflux disease
Family History: No family history of melanoma. Father had basal cell carcinoma.
Social History: office worker, does not smoke.
Allergies: no known drug allergies.
Medications: Cimetidine

Review of systems: Positive findings on review of systems include occasional abdominal pain relieved by cimetidine and seasonal allergies. All other review of systems are negative.

Physical Exam, Assessment, and Plan

Via teledermatology camera, on examination, the patient is well-appearing, in no acute distress, and alert and oriented. Mood and affect are normal. An examination of the scalp, face, neck, eyelids, bilateral arms, digits, chest including breasts, abdomen, back, and bilateral lower extremities was within normal limits except for the findings noted below:

1. 6x6 mm pearly papule with central erosion on the left aspect of the forehead
2. multiple verrucous, stuck-on papules on the back and lower extremities
3. two erythematous, gritty patches on the right cheek

Based on the images transmitted via the teledermatology camera and the clinical history available to me, my clinical impressions and recommendations are as follows:

1. Basal cell carcinoma on the left aspect of the forehead: I recommend a shave biopsy of this lesion for pathologic examination. If pathology confirms the diagnosis of basal cell carcinoma, the patient will most likely need Mohs surgery for treatment.
2. Seborrheic Keratosis on the back and lower extremities: Benign nature of these lesions were explained to the patient.
3. Actinic Keratoses x2 on the right cheek: I recommend cryotherapy treatment to these two lesions. If the lesions persist or recur after the treatment, I would like to see the patient again via teledermatology sessions.

Sun protection education was reviewed with the patient, including using a sunscreen with broadspectrum protection with SPF of at least 30 and above, with frequent re-application.

If you have any questions, please feel free to contact me at 916-XXX-XXXX.

Sincerely,

April Armstrong, MD
Attending Physician
Department of Dermatology
UC Davis Health System
About the Authors

Marc Goldyne, MD, PhD
Currently, Dr. Goldyne is a Clinical Professor of Dermatology at UCSF. He also is in private practice in San Francisco and served as the 2003-2004 President of the San Francisco Dermatological Society. Since 1999, he has practiced both live interactive and store and forward teledermatology interacting with the Anthem Blue Cross of California Telemedicine Program and has, to date, performed over 2500 teleconsultations. He is a member of the American Telemedicine Association and currently serves as the vice chair of the Teledermatology Special Interest Group. He is a Life Member of the American Academy of Dermatology and serves on its Telemedicine Task Force.

April W. Armstrong, MD
Currently, Dr. Armstrong is the Director of Teledermatology at University of California Davis. She provides real-time, videoconference-based teledermatology consultations to 31 rural sites in California. To date, she has performed over 1200 real-time teledermatology consultations to patients in Massachusetts and California. She is a member of the Teledermatology Special Interest Group of the American Telemedicine Association and Telemedicine Task Force of the American Academy of Dermatology.
tab 7 goes before page 206
tab 8 goes *after* page 234
STATE TELEHEALTH LAWS

& REIMBURSEMENT POLICIES
State Telehealth Laws and Medicaid Program Policies

INTRODUCTION
The Center for Connected Health Policy’s (CCHP) Fall 2018 release of its report on “State Telehealth Laws and Reimbursement Policies” offers policymakers, health advocates, and other interested health care professionals a freshly redesigned summary guide of telehealth-related policies, laws, and regulations for all 50 states and the District of Columbia. States continue to pursue their own unique set of telehealth policies as more and more legislation is introduced each year. Some states have incorporated policies into law, while others have addressed issues such as definition, reimbursement policies, licensure requirements, and other important issues in their Medicaid Program Guidelines.

While this guide focuses primarily on Medicaid fee-for-service policies, information on managed care is noted in the report if it was available. The report also indicates any particular areas where we were unable to find information. Every effort was made to capture the most recent policy language in each state as of September 2018. Recently passed legislation and regulation have also been included in this version of the document with their effective date noted in the report (if applicable). This information also is available electronically in the form of an interactive map and search tool accessible on our website cchpca.org. Consistent with previous editions, the information will be updated biannually, as laws, regulations and administrative policies are constantly changing.

TELEHEALTH POLICY TRENDS
While many states are beginning to expand telehealth reimbursement, others continue to restrict and place limitations on telehealth delivered services. Although each state’s laws, regulations, and Medicaid program policies differ significantly, certain trends are evident when examining the various policies. Live video Medicaid reimbursement, for example, continues to far exceed reimbursement for store-and-forward and remote patient monitoring (RPM). However, over the past year there has been a slight uptake in remote patient monitoring reimbursement, although generally on a limited basis. Store-and-forward reimbursement remains limited with many states only reimbursing for teleradiology (which CCHP does not count as store and forward) or other very specific specialties or forms of store-and-forward. For example, Connecticut is allowing for store-and-forward reimbursement for physician-to-physician email consultations (known as eConsult) exclusively, while Virginia has store-and-forward and RPM reimbursement, but limited it to specific specialties. Other noteworthy trends include the addition of the home and schools as an eligible originating site in some states, and the inclusion of teledentistry and substance use disorder services as a specialty qualifying for Medicaid reimbursement and/or required to be reimbursed by private insurers.

Additionally, some state Medicaid programs have begun incorporating specific documentation and/or confidentiality, privacy and security guidelines within their manuals for telehealth specifically. On the private payer side, some states have passed wide ranging laws to require telehealth reimbursement (most recently Kansas), while others limit reimbursement to specific specialties, such as Utah (telepsychiatry only). Laws and regulations allowing practitioners to prescribe medications through live video interactions have also increased, as well as a few states even allowing for the prescription of controlled substances over telehealth within federal limits.
A few additional significant findings include:

- Forty-nine states and Washington DC provide reimbursement for some form of live video in Medicaid fee-for-service. This number has remained the same since Spring 2018.
- Eleven state Medicaid programs reimburse for store-and-forward. However, four additional jurisdictions (D.C., HI, MS, NY and NJ) have laws requiring Medicaid reimburse for store-and-forward but as of the creation of this edition, yet to have any official Medicaid policy indicating this is occurring.
- Twenty state Medicaid programs provide reimbursement for RPM. As is the case for store-and-forward, four jurisdictions (D.C., HI, NY and NJ) have laws requiring Medicaid reimburse for RPM but don’t have any official Medicaid policy. Kentucky Medicaid is also required to create a RPM pilot, but CCHP has not seen any evidence that the pilot has been established.
- Seven state Medicaid programs (Alaska, Arizona, Maryland, Minnesota, Nevada, Virginia and Washington) reimburse for all three, although certain limitations apply.

**HOW TO USE THIS REPORT**

Telehealth policies are organized into three categories that address Medicaid reimbursement, private payer law and professional regulation/health & safety. Within those category areas, topic focuses include modality of reimbursement (for Medicaid), requirements and parity (for private payer law), licensing, consent and online prescribing (for professional regulation/health & safety). In many instances the specific policy is found in law and/or regulations and administrative policy, but that is not always the case. This report primarily addresses the individual state’s policies that govern telehealth use when seeking Medicaid coverage for service. However, we have also included a specific category that describes whether a state has established any specific policies that require private insurers to pay for telehealth services. A glossary is also available at the end of the report.

We hope you find the report useful, and welcome your feedback and questions. You can direct your inquiries to Mei Kwong, CCHP Executive Director or Christine Calouro, Policy Associate, at info@cchpca.org. We would also like to thank our colleagues at each of the twelve HRSA-funded Regional Telehealth Resource Centers who contributed to ensuring the accuracy of the information in this document. For further information, visit cchpca.org.

This report is for informational purposes only, and is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Always consult with counsel or appropriate program administrators.

**Mei Wa Kwong, JD**
Executive Director
October 2018

This project was partially funded by The California HealthCare Foundation and The National Telehealth Policy Resource Center program is made possible by Grant #G22RH30365 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

The Center for Connected Health Policy is a program of the Public Health Institute.
The Fall 2018 release of the Center for Connected Health Policy’s (CCHP) report of state telehealth laws and Medicaid reimbursement policies is the sixteenth updated version of the report since it was first released in 2013. This version of the report reflects a reformatted and redesigned layout for the information itself. Like its previous iterations, the report is updated on a biannual basis, in spring and fall. An interactive map version of the report (also reformatted) is available on CCHP’s website, cchpca.org. Due to constant changes in laws, regulations, and policies, CCHP will continue to update the information in both PDF and map formats twice a year to keep it as accurate and timely as possible.

It should be noted that even if a state has enacted telehealth policies in statute and/or regulation, these policies may not have been incorporated into its Medicaid program. Throughout the report, CCHP has notated changes in law that have not yet been incorporated into the Medicaid program, as well as laws and regulations that have been approved, but not yet taken effect.

**METHODOLOGY**

CCHP examined state law, state administrative codes, and Medicaid provider manuals as the report’s primary resources. Additionally, other potential sources such as releases from a state’s executive office, Medicaid notices, transmittals or Agency newsletters were also examined for relevant information. In some cases, CCHP directly contacted state Medicaid personnel in order to clarify specific policy issues. Most of the information contained in this report specifically focuses on fee-for-service; however, information on managed care plans has also been included if available from the utilized sources. Newly approved regulations related to specific telehealth standards for various professions are noted in the “Miscellaneous” section of the state’s Professional Regulation/Health & Safety category area.

The survey focused on three primary areas for telehealth policy including Medicaid reimbursement, private payer laws and professional regulation/health & safety requirements. Within the larger categories listed above, information is organized into various topic and subtopic areas, based upon the frequency they have appeared in discussions and questions around telehealth reimbursement and laws. These topic areas include:

- **Medicaid Reimbursement:**
  - Definition of the term telemedicine/telehealth
  - Reimbursement for live video
  - Reimbursement for store-and-forward
  - Reimbursement for remote patient monitoring (RPM)
  - Reimbursement for email/phone/fax
  - Consent issues
  - Out of state providers
- **Private payer laws**
  - Definitions
  - Requirements
• Parity (service and payment)

• Professional Regulation
  • Definitions
  • Consent
  • Online Prescribing
  • Cross-State Licensing

KEY FINDINGS
No two states are alike in how telehealth is defined and regulated. While there are some similarities in language, perhaps indicating states may have utilized existing verbiage from other states, noticeable differences exist. These differences are to be expected, given that each state defines its Medicaid policy parameters, but it also creates a confusing environment for telehealth participants to navigate, particularly when a health system or practitioner provides health care services in multiple states. In most cases, states have moved away from duplicating Medicare’s restrictive telehealth policy, with some reimbursing a wide range of practitioners and services, with little to no restrictions.

As noted previously, even if a state has enacted telehealth policies in statute and/or regulation, these policies may not have been incorporated into its Medicaid program. In the findings below, there are a few cases in which a law has passed requiring Medicaid reimbursement of a specific telehealth modality or removal of restrictions, but Medicaid policies have yet to reflect this change. CCHP has based its findings on current Medicaid policy according to those listed in their program regulations, manuals or other official documentation. Requirements in newly passed legislation will be incorporated into the findings section of future editions of CCHP’s report once they are implemented in the Medicaid program, and CCHP has located official documentation confirming this.

Below are summarized key findings in each category area contained in the report.

DEFINITIONS
States alternate between using the term “telemedicine” or “telehealth”. In some states both terms are explicitly defined in law and/or policy and regulations. “Telehealth” is sometimes used to reflect a broader definition, while “telemedicine” is used mainly to define the delivery of clinical services. Additional variations of the term, primarily utilizing the “tele” prefix are also becoming more prevalent. For example, the term “telepractice” is being used frequently as it relates to physical and occupational therapy, behavioral therapy, and speech language pathology. “Telesychiatry” is also a term commonly used as an alternative when referring specifically to psychiatry services. Many professional boards are also adopting definitions of telehealth specific to their particular profession, in some cases, creating many different definitions for the term within a state’s administrative code. For example, Wyoming passed legislation encouraging each Board to adopt their own definition of the term “telehealth”. This has the potential to add to the already complex telehealth policy environment.

Some states put specific restrictions within the definitions, which often limit the term to “live” or “interactive”, excluding store-and-forward and RPM from the definition and subsequently from reimbursement. The most common restriction states place on the term telemedicine/telehealth is the exclusion of email, phone, and/or fax from the definition. Forty-nine states and the District of Columbia have a definition in law, regulation, or their Medicaid program for telehealth, telemedicine, or both. Only Alabama lacks a legal definition for either term.

MEDICAID REIMBURSEMENT
Forty-nine states and the District of Columbia have some form of Medicaid reimbursement for telehealth in their public...
program. The only state that CCHP determined did not have any written definitive Medicaid reimbursement policy is Massachusetts.

However, the extent of reimbursement for telehealth delivered services is less clear in some states than others. For example, Iowa’s Medicaid program issued a broad regulatory statement confirming that they do provide reimbursement for telehealth in 2016. This policy change came as a result of IA Senate Bill 505 which required the Department of Human Services to adopt formal rules regarding their longstanding (although unwritten) policy to provide reimbursement for telehealth. However, the rule that was adopted simply states that “in-person contact between a provider and patient is not required for payment for services otherwise covered and appropriately provided through telehealth as long as it meets the generally accepted health care practices and standards prevailing in the applicable professional community.” Neither the legislation nor the rule provides a definition of telehealth, which leaves the policy vague and up for interpretation. Therefore, it is unclear whether store-and-forward or RPM services would fall under the umbrella of this telehealth policy.

It should be noted that Massachusetts employs managed care plans in its Medicaid program. CCHP does not examine whether specific participating managed care plans provided any form of telehealth reimbursement.

**Live Video**
The most predominantly reimbursed form of telehealth modality is live video, with every state offering some type of live video reimbursement in their Medicaid program (except Massachusetts). However, what and how it is reimbursed varies widely. The spectrum ranges from a Medicaid program in a state like New Jersey, which will only reimburse for telepsychiatry services, to states like California, which reimburses for live video across a wide variety of medical specialties. In addition to restrictions on specialty type, many states have restrictions on:

- The type of services that can be reimbursed, e.g. office visit, inpatient consultation, etc.;
- The type of provider that can be reimbursed, e.g. physician, nurse, physician assistant, etc.; and
- The location of the patient, referred to as the originating site.

These restrictions have been noted within the report to the extent possible.

While there has been no change to the number of states offering reimbursement for live video, many states have made adjustments to their policies, in many cases broadening reimbursement to include more specialties, services (CPT codes) and eliminating originating site restrictions. For example, reimbursement for teledentistry has grown significantly over the past year, with AZ, CA, GA, MN, NC, NY, and WA all offering reimbursement in the specialty. Other states are taking steps to eliminate unnecessary restrictions. This has been evident in the state of Vermont, which took steps earlier this year to eliminate provider type restrictions in their Medicaid program (now only requiring that a provider be enrolled in the Medicaid program), as well as eliminated the need to document the reason that the visit was occurring over telemedicine as opposed to in-person. Likewise Arkansas also eliminated their list of eligible providers and originating sites, allowing for any enrolled Medicaid provider to provide services to a Medicaid beneficiary.

**Store-and-Forward**
Store-and-forward services are only defined and reimbursed by a handful of state Medicaid Programs. In many states, the definition of telemedicine and/or telehealth stipulates that the delivery of services must occur in “real time,” automatically excluding store-and-forward as a part of telemedicine and/or telehealth altogether in those states. Of those states that do reimburse for store-and-forward services, some have limitations on what will be reimbursed. For example, California only reimburses for teledermatology, teleophthalmology and teledentistry. Currently, eleven state Medicaid programs reimburse for store-and-forward. This number does not include states that only reimburse for teleradiology (which is commonly reimbursed, and not always considered ‘telehealth’). Maryland’s Medicaid program specifies that while they don’t reimburse for store-and-forward, they do not consider use of the technology in dermatology, ophthalmology and
radiology to fit into the definition of store-and-forward. Because these are specialties that typically fit into the store-and-forward definition in other states (for example, California), Maryland was included as reimbursing for store-and-forward for purposes of this report. States that do reimburse for store-and-forward include:

1. Alaska  
2. Arizona  
3. Connecticut  
4. California  
5. Georgia  
6. Maryland  
7. Minnesota  
8. New Mexico  
9. Nevada  
10. Virginia  
11. Washington

Recent legislation passed in the District of Columbia (D.C.) requires D.C. Medicaid to begin reimbursing store-and-forward. However, the law doesn’t apply to Medicaid until its fiscal effect is included in an approved budget and financial plan. CCHP has not been able to locate any update to D.C.’s Medicaid regulations or manuals to reflect this change and therefore has not counted it in this list.

In addition to the states above, four other states have laws requiring Medicaid reimburse for store-and-forward services, but CCHP has not been able to locate any official Medicaid policy indicating that they are in fact reimbursing. They include Mississippi, New Jersey, New York and Hawaii. Note that Hawaii and New York both have approved Medicaid State Plan Amendments allowing them to reimburse for store-and-forward within their Medicaid programs but CCHP is still awaiting official written Medicaid policy indicating that they are actively reimbursing for store-and-forward. Other states that CCHP has included in this list in the past including Missouri, Illinois and Oklahoma were removed because CCHP determined that their reimbursement of store-and-forward was not clear within their written policies this update. In some cases, although a definition of telehealth or telemedicine applicable to their Medicaid program included store-and-forward, there was no further indication of the modality being reimbursed, or the only specialty referenced was teleradiology which CCHP does not count as store-and-forward reimbursement for purposes of this list.

It should also be noted that Connecticut has limited reimbursement to a very specific type of store-and-forward they term “eConsult”, which is a certain secure email system that allows healthcare providers to engage in email consultations with each other regarding a particular patient.

**Remote Patient Monitoring (RPM)**

Twenty states have some form of reimbursement for RPM in their Medicaid programs. As with live video and store-and-forward reimbursement, many of the states that offer RPM reimbursement have a multitude of restrictions associated with its use. The most common of these restrictions include only offering reimbursement to home health agencies, restricting the clinical conditions for which symptoms can be monitored, and limiting the type of monitoring device and information that can be collected.

For example, Colorado requires the patient to be receiving services for at least one of the following: congestive heart failure, chronic obstructive pulmonary disease, asthma, or diabetes. Further, the patient must still meet other conditions. The states that currently offer some type of RPM reimbursement in their Medicaid program are:

1. Alabama  
2. Alaska  
3. Arizona  
4. Colorado  
5. Illinois  
6. Indiana  
7. Kansas  
8. Louisiana  
9. Maine  
10. Maryland  
11. Minnesota  
12. Mississippi  
13. Missouri  
14. Nebraska  
15. South Carolina  
16. Texas  
17. Utah  
18. Vermont  
19. Virginia  
20. Washington
Recent legislation passed in the District of Columbia requires D.C. Medicaid to begin reimbursing remote patient monitoring. However, the law doesn’t apply to Medicaid until its fiscal effect is included in an approved budget and financial plan. CCHP has not been able to locate any update to D.C.’s Medicaid regulations or manuals to reflect this change and therefore has not counted it in this list.

As is the situation with store-and-forward, Hawaii, New York and New Jersey all have laws requiring the Medicaid programs reimburse for RPM, however there is no official written Medicaid policy indicating that they have implemented it and how a provider can seek reimbursement, therefore CCHP has not counted them in its official count. Additionally, while Kentucky Medicaid is required to establish a RPM pilot project, CCHP has not been able to locate any official announcement from their Medicaid program of such a pilot. Also, RPM is sometimes reimbursed through other state Departments separate from Medicaid, for example, South Dakota, where RPM is reimbursed through their Department of Aging Services.

Note that the states listed are only for RPM in the home where some specific information related to technology or telecommunication could be found. Some states reimburse for home health services, but no further details of what modality was reimbursed could be located. Additionally, some states may already be reimbursing for tele-ICU (a form of RPM); however, these were not included.

Email/Phone/Fax
Email, telephone, and fax are rarely acceptable forms of delivery unless they are in conjunction with some other type of system. States either are silent or explicitly exclude these forms, sometimes even within the definition of telehealth and/or telemedicine.

Transmission/Facility Fee
Thirty-four states will reimburse either a transmission, facility fee, or both. Of these, the facility fee is the most common. Policies often stipulate a specific list of facilities eligible to receive the facility fee. Medicare also reimburses for a facility fee for the originating site provider.

Eligible Providers
While many state Medicaid programs are silent, some states limit the types of providers that can provide services at the distant site through telehealth. These lists vary from being extremely selective in the provider types that are eligible (for example, only physicians, certified registered nurse practitioner and certified nurse midwives in Pennsylvania), to more expansive eligible provider lists, such as in Virginia, which includes over thirteen provider types. Because federally qualified health centers (FQHCs) and rural health centers (RHCs) bill as entities rather than as providers, these lists often exclude them. Medicare has also excluded these clinics from billing for telehealth delivered services as distant site providers (although they do qualify for the originating site facility fee). States that explicitly allow FQHCs and/or RHCs to bill as distant site providers include:

1. Arkansas (RHC)
2. District of Columbia (FQHC & RHC)
3. Georgia (FQHC & RHC)
4. Idaho (FQHC & RHC)
5. Illinois (FQHC & RHC)
6. Indiana (FQHC & RHC)
7. Maine (FQHC & RHC)
8. Maryland (FQHC)
9. Missouri (RHC)
10. Ohio (FQHC)
11. Pennsylvania (FQHC & RHC) – Behavioral Health only
12. Utah (FQHC & RHC)
13. Wisconsin (FQHC & RHC)
Geographic & Facility Originating Site Restrictions

The practice of restricting reimbursable telehealth services to rural or underserved areas, as is done in the Medicare program, is decreasing. New Hampshire was the last remaining state to follow Medicare’s telehealth policy, restricting originating sites to rural health professional shortage areas or non-Metropolitan Statistical Area (MSA), but eliminated the policy with the passage of recent legislation, although other Medicare restrictions on telehealth are still maintained in New Hampshire Medicaid. States that continue to have telehealth geographic restrictions are more ambiguous in their policies. In South Dakota’s Medicaid program, they simply state that an originating and distant site cannot be located in the same community. However, only six states currently have these types of restrictions, continuing the trend to eliminate such limitations. Some are restricted to only certain specialties, such as Maryland’s geographic restriction only applying to mental health, and Minnesota’s geographic requirement only applying to Medication Therapy Management Services. Although Hawaii passed a law prohibiting a geographic limitation for telehealth in their Medicaid program, such language is still present in their Medicaid regulation.

A more common practice is for state Medicaid programs to limit the type of facility that may be an originating site, often excluding the home as a reimbursable site, impacting RPM as a result. Currently twenty-three jurisdictions have a specific list of sites that can serve as an originating site for a telehealth encounter. This number has remained unchanged since April 2017. During this update, although some states eliminated their originating site list (such as Arkansas), others added an eligible site list, (such as Nevada). Additionally, more state Medicaid programs are now explicitly allowing the home to serve as an originating site, with thirteen states (DE, CO, MD, MI, MN, MT, NV, NY, SC, TX, VT, WA and WY) adding the home explicitly into their Medicaid policy since Aug. 2016. In some cases, certain restrictions apply. Most states that allow the home as an originating site do not that they are not eligible for an originating site facility fee. Some state Medicaid programs only allow the home to serve as an originating site for certain specialties such as mental health, while others require a provider to be physically with the patient in the home to qualify for reimbursement. More states are also allowing schools to serve as an originating site, with fifteen jurisdictions explicitly allowing schools to be originating sites for telehealth delivered services, although restrictions often apply.

CONSENT

Thirty-eight jurisdictions include some sort of informed consent requirement in their statutes, administrative code, and/or Medicaid policies. This requirement can sometimes apply to the Medicaid program, a specific specialty or all telehealth encounters that occur in the state, depending on how and where the policy is written. States with informed consent policies include:

1. Alabama
2. Arizona
3. Arkansas
4. California
5. Colorado
6. Connecticut
7. District of Columbia
8. Delaware
9. Georgia
10. Idaho
11. Indiana
12. Kansas
13. Kentucky
14. Louisiana
15. Maine
16. Maryland
17. Michigan
18. Minnesota (alcohol & abuse program)
19. Mississippi
20. Missouri
21. Nebraska
22. New Hampshire
23. New Jersey
24. New York
25. Ohio
26. Oklahoma
27. Oregon (Physical Therapy & Community Treatment)
28. Pennsylvania
29. Rhode Island
30. South Carolina
31. Tennessee
32. Texas
33. Vermont
34. Virginia
35. Washington
36. West Virginia
37. Wisconsin
38. Wyoming
**LICENSURE**

Nine state medical (or osteopathic) boards issue special licenses or certificates related to telehealth. The licenses could allow an out-of-state provider to render services via telemedicine in a state where they are not located, or allow a clinician to provide services via telehealth in a state if certain conditions are met (such as agreeing that they will not open an office in that state). States with such licenses are:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Alabama</td>
</tr>
<tr>
<td>2.</td>
<td>Louisiana</td>
</tr>
<tr>
<td>3.</td>
<td>Maine</td>
</tr>
<tr>
<td>4.</td>
<td>Minnesota</td>
</tr>
<tr>
<td>5.</td>
<td>New Mexico</td>
</tr>
<tr>
<td>6.</td>
<td>Ohio</td>
</tr>
<tr>
<td>7.</td>
<td>Oregon</td>
</tr>
<tr>
<td>8.</td>
<td>Tennessee</td>
</tr>
<tr>
<td>9.</td>
<td>Texas</td>
</tr>
</tbody>
</table>

The Tennessee Medical Board eliminated their telemedicine license effective Oct. 31, 2016. Individuals granted a telemedicine license under the former version of the rule may apply to have the license converted to a full license. Under certain circumstances individuals who do not convert to a full license can retain their telemedicine license. Tennessee's Osteopathic Board will continue to issue telemedicine licenses as of this time.

Like Tennessee, Montana and Nevada also both dropped their telemedicine special license in 2016, and are among twenty-four states and one jurisdiction (D.C.) that adopted the Federation of State Medical Boards (FSMB)’s Interstate Medical Licensure Compact (IMLC) in its place. The Compact allows for an Interstate Commission to form an expedited licensure process for licensed physicians to apply for licenses in other states. Jurisdictions that have adopted the IMLC Compact language include:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Alabama</td>
</tr>
<tr>
<td>2.</td>
<td>Arizona</td>
</tr>
<tr>
<td>3.</td>
<td>Colorado</td>
</tr>
<tr>
<td>4.</td>
<td>District of Columbia</td>
</tr>
<tr>
<td>5.</td>
<td>Idaho</td>
</tr>
<tr>
<td>6.</td>
<td>Illinois</td>
</tr>
<tr>
<td>7.</td>
<td>Iowa</td>
</tr>
<tr>
<td>8.</td>
<td>Kansas</td>
</tr>
<tr>
<td>9.</td>
<td>Maine</td>
</tr>
<tr>
<td>10.</td>
<td>Maryland</td>
</tr>
<tr>
<td>11.</td>
<td>Minnesota</td>
</tr>
<tr>
<td>12.</td>
<td>Mississippi</td>
</tr>
<tr>
<td>13.</td>
<td>Montana</td>
</tr>
<tr>
<td>14.</td>
<td>Nebraska</td>
</tr>
<tr>
<td>15.</td>
<td>Nevada</td>
</tr>
<tr>
<td>16.</td>
<td>New Hampshire</td>
</tr>
<tr>
<td>17.</td>
<td>Pennsylvania</td>
</tr>
<tr>
<td>18.</td>
<td>(Implementation delayed)</td>
</tr>
<tr>
<td>19.</td>
<td>South Dakota</td>
</tr>
<tr>
<td>20.</td>
<td>Tennessee</td>
</tr>
<tr>
<td>21.</td>
<td>(Implementation delayed)</td>
</tr>
<tr>
<td>22.</td>
<td>Utah</td>
</tr>
<tr>
<td>23.</td>
<td>Vermont</td>
</tr>
<tr>
<td>24.</td>
<td>West Virginia</td>
</tr>
<tr>
<td>25.</td>
<td>Washington</td>
</tr>
<tr>
<td>26.</td>
<td>Wisconsin</td>
</tr>
<tr>
<td>27.</td>
<td>Wyoming</td>
</tr>
</tbody>
</table>

Besides the IMLC, there are also three additional Compacts to be aware of that are currently active or soon to be active, including:

- The Nurses Licensure Compact which currently has 31 state members.
- The Physical Therapy Compact which currently has 21 members.
- The Psychology Interjurisdictional Compact which currently has 7 members (Compact doesn’t become active until 1/1/2020 unless another state adopts Compact with an earlier effective date).
Still other states have laws that don’t specifically address telehealth and/or telemedicine licensing, but make allowances for practicing in contiguous states, or in certain situations where a temporary license might be issued provided the specific state’s licensing conditions are met.

ONLINE PRESCRIBING

There are a number of nuances and differences across the states related to the use of technology and prescribing. However, most states consider using only an internet/online questionnaire to establish a patient-provider relationship (needed to write a prescription in most states) as inadequate. States may also require that a physical exam be administered prior to a prescription being written, but not all states require an in-person examination, and some specifically allow the use of telehealth to conduct the exam. Other states have relaxed laws and regulations around online prescribing. For example, while more stringent policies typically exist restricting practitioners from prescribing controlled substances through telehealth, a few states have begun opting to explicitly allow for the prescribing of controlled substances within federal limits. Many of these laws have passed as a result of the opioid epidemic and the need to prescribe certain medications associated with medication assisted therapy (MAT). Most recently, West Virginia passed new legislation explicitly allowing a practitioner to provide aspects of medication-assisted treatment (MAT) through telehealth if it is within their scope of practice. New York’s Office of Alcoholism and Substance Abuse Services also adopted special requirements for the prescribing of buprenorphine (commonly used in MAT). Michigan and Virginia also passed laws in 2017 allowing for the prescribing of Schedule II-V controlled substances through telehealth under certain circumstances. In addition to more states explicitly allowing for the prescribing of controlled substances using telehealth, some Medicaid programs are also beginning to pay for medication therapy management services when provided through telehealth including, MN, MI and LA. Indiana Medicaid also issued a clarification to their providers prohibiting prescription via telemedicine of controlled substances except in cases in which the opioid is partial agonist and is being used to treat or manage opioid dependence.

An increasing number of states are also passing legislation directing healthcare professional boards to adopt practice standards for its providers who utilize telehealth. Medical and Osteopathic Boards often address issues of prescribing in such regulatory standards. This often occurs immediately following the passage of a private payer reimbursement bill in a state. This was most recently the case with North Dakota, whose Board of Medicine passed telehealth practice standards following the passage of the state’s first private payer telehealth reimbursement bill in 2017. The new rule does allow a patient and licensee to establish a relationship over telemedicine.

PRIVATE PAYERS

Currently, thirty-nine states and DC have laws that govern private payer telehealth reimbursement policies. Kansas, Iowa and Utah passed telehealth private payer reimbursement legislation, although they all don’t go into effect until Jan. 1, 2019. Additionally, only a few private payer laws require that the reimbursement amount for a telehealth-delivered service be equal to the amount that would have been reimbursed had the same service been delivered in-person. Because so many states now have private payer reimbursement bills, the more common policy change in relation to private payers, is to amend a law to expand its applicability to additional specialties or policy types. For example, Michigan recently expanded the applicability of their private payer law to include dental coverage.

Utah, on the other hand, who recently passed their first private payer bill, singles out telepsychiatry services. While they are not the only state to limit private payer telehealth reimbursement requirements to a specific specialty (see Arizona and Alaska), they are the first state to make a distinction between in-network and out-of-network providers in their law. Under the new law (effective Jan. 1, 2019), a health benefit plan is required to cover mental health services for in-network physicians, or out-of-network psychiatrists only if an in-network consultant is not made available within seven business days after the initial request.
Kansas was the only state to add a telehealth private payer law since CCHP’s Spring 2018 update. In their law, Kansas decided to include a provision that ensures insurers are not requiring patients to utilize telemedicine in lieu of receiving in-person services from an in-network provider. This type of provision may become more common in private payer laws, as policymakers look to build in protections for patients.

**ADDITIONAL FINDINGS & POTENTIAL FUTURE TRENDS**

CCHP noted in the April 2017 update of this report that states were moving away from the GT modifier and utilizing either the newly adopted CMS place of service code 02 or the 95 modifier adopted by the American Medical Association, or a combination of two or more of these. States that CCHP identified in its search that adopted either code are listed below.

<table>
<thead>
<tr>
<th>02 POS Code</th>
<th>95 Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>California</td>
</tr>
<tr>
<td>Hawaii</td>
<td>Hawaii</td>
</tr>
<tr>
<td>Indiana</td>
<td>Indiana</td>
</tr>
<tr>
<td>Iowa</td>
<td>Michigan</td>
</tr>
<tr>
<td>Kansas</td>
<td>North Dakota</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Texas</td>
</tr>
<tr>
<td>Missouri</td>
<td>Washington</td>
</tr>
<tr>
<td>Montana</td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td></td>
</tr>
<tr>
<td>Vermont</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td></td>
</tr>
</tbody>
</table>

*Not a complete list.

During this update, four new states added the requirement to use the 02 POS code and three states added the requirement to use the 95 modifier.

To learn more about state telehealth related legislation, visit CCHP’s interactive map at cchpca.org.

This report is for informational purposes only, and is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Always consult with counsel or appropriate program administrators.
Medicaid Program: Alabama Medicaid
Program Administrator: Alabama Medicaid Agency
Regional Telehealth Resource Center: Southeast Telehealth Resource Center
Covers the States of: Alabama, Florida, Georgia & South Carolina
www.setrc.us

### Summary

Alabama Medicaid reimburses for live video under some circumstances. They make no reference to store-and-forward reimbursement, but the program reimburses for In-Home Monitoring through the Patient’s 1st program for diabetes and Chronic Heart failure, although it’s not considered to fall under the telemedicine program.

For all telemedicine services, an appropriately trained staff member or employee familiar with the patient or the treatment plan must be immediately available in-person to the patient.


Effective for dates of service 1/16/2012 and thereafter, all physicians with an Alabama license, enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to participate in the telemedicine program:

- Physicians must be enrolled with Alabama Medicaid with a specialty type of 931 (Telemedicine Service)
- Physician must submit the telemedicine Service Agreement/Certification form
- Physician must obtain prior consent from the recipient before services are rendered. This will count as part of each recipient’s benefit limit of 14 annual physician office visits currently allowed.


### Definitions

There is no explicit definition of “telemedicine” given in state Medicaid policy. However, the provider manual states, “Services must be administered via an interactive audio and video telecommunications system which permits two-way communication between the distant site physician and the origination site where the recipient is located (this does not include a telephone conversation, electronic mail message, or facsimile transmission between the physician, recipient, or a consultation between two physicians)."

<table>
<thead>
<tr>
<th>Policy</th>
<th>Live Video</th>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Alabama Medicaid reimburses for live video for certain services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alabama Medicaid reimburses for the following services:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Consults;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Office or other outpatient visits;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Individual psychotherapy;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Psychiatric diagnostic services;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Neurobehavioral status exams.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>However, for some specialties, special conditions or circumstances must be present for reimbursement to occur.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For rehabilitative services, the originating site must be:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Physician’s office;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Hospital;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Critical Access Hospital;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Rural Health Clinic;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Federally Qualified Health Center;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Community mental health center (to include co-located sites with partnering agencies;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Public health department.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For rehabilitative services, the originating site must be located in Alabama. The distant site may be located outside of Alabama as long as the physician has an Alabama license and is enrolled as an Alabama Medicaid provider.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Live Video</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Policy</strong></td>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td><strong>Store-and-Forward</strong></td>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td><strong>Eligible Services/Specialties</strong></td>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td><strong>Geographic Limits</strong></td>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td><strong>Transmission Fee</strong></td>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Policy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alabama Medicaid will reimburse remote patient monitoring through the In Home Monitoring Program. The program is a joint effort between the Agency, the University of Alabama and the Alabama Department of Public Health (ADPH). Must be referred to the Patient’s 1st program by any source including a physician, Patient 1st care coordinator, patient care network, patient or caregiver, the Health Department, hospitals, home health agencies or community based organizations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients with the following medical conditions may register for the program:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Congestive Heart Failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider Limitations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data is transmitted to an ADPH nurse care manager.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Restrictions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Alabama Department of Public Health (ADPH) Nurse Care Manager evaluates the patient, provides any needed equipment such as a scale, glucometer, blood pressure cuff and phone with a speaker.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data transmission occurs through a secure telephone call.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Email / Phone / Fax</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reimbursement for email.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reimbursement for telephone.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reimbursement for FAX.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Consent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A written informed consent is required prior to an initial telemedicine service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--</td>
<td></td>
</tr>
</tbody>
</table>
| Out of State Providers | Providers must have an Alabama license.  
| Miscellaneous | No reference found. |
| Definitions | No reference found. |
| Requirements | No reference found. |
| Parity |  |
| Service Parity | No reference found. |
| Payment Parity | No reference found. |

Private Payer Laws
<table>
<thead>
<tr>
<th>Professional Regulation / Health &amp; Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definitions</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Consent</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Online Prescribing</strong></td>
</tr>
<tr>
<td>The Alabama Board of Medical Examiners holds the position that, when prescribing medications to an individual, the prescriber, when possible, should personally examine the patient. Prescribing medications for patients the physician has not personally examined may be suitable for certain circumstances, including telemedicine. Licensees are expected to adhere to federal and state statute regarding prescribing of controlled substances.</td>
</tr>
<tr>
<td><strong>Source:</strong> AL Admin. Code. r. 540-X-9-.11.</td>
</tr>
<tr>
<td><strong>Cross-State Licensing</strong></td>
</tr>
<tr>
<td>“A special purpose license allowing practitioners licensed in other states to practice across state lines may be issued.”</td>
</tr>
<tr>
<td><strong>Source:</strong> Code of AL Sec. 34-24-502 – 507.</td>
</tr>
<tr>
<td>AL passed legislation to be a part of the interstate licensing compact.</td>
</tr>
<tr>
<td><strong>Source:</strong> AL Act 2015-197 (2015).</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
</tr>
<tr>
<td><strong>Professional Board Telehealth-Specific Regulations</strong></td>
</tr>
<tr>
<td>• AL Board of Optometrists (Source: AL Admin Code 630-X-13-.02)</td>
</tr>
<tr>
<td>• AL Board of Nursing (Source: AL Admin Code 610-X-6-.16).</td>
</tr>
</tbody>
</table>
**Medicaid Program:** Alaska Medicaid  
**Program Administrator:** Alaska Dept. of Health and Social Services, Division of Public Assistance  
**Regional Telehealth Resource Center:** Northwest Regional Telehealth Resource Center  
**Covers the States of:** Alaska, Oregon, Idaho, Montana, Utah, Washington & Wyoming  
**www.nrtrc.org**

---

**Summary**

Alaska reimburses for Live Video, Store & Forward and Remote Patient Monitoring, although some restrictions apply.

---

**Definitions**

“Alaska Medicaid will pay for telemedicine services delivered in the following manner:

- **Interactive method:** Provider and patient interact in ‘real-time’ using video/camera and/or dedicated audio conference equipment.
- **Store-and-forward method:** The provider sends digital images, sounds, or previously recorded video to a consulting provider at a different location. The consulting provider reviews the information and reports back his or her analysis.
- **Self-monitoring method:** The patient is monitored in his or her home via a telemedicine application, with the provider indirectly involved from another location.”

*Source: State of AK Dept. of Health and Social Svcs., Alaska Medical Assistance Provider Billing Manuals for Community Behavioral Health Services, Early and Periodic Screening, Diagnosis, and Treatment, Hospice Care, Inpatient Psychiatric Services, Independent Laboratory Services, Appendices. (Accessed Aug, 2018).*

“Telemedicine means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of medical data through audio, video, or data communications that are engaged in over two or more locations between providers who are physically separated from the patient or from each other.”

*Source: AK Admin. Code, Title 7, 12.449 (2012).*
Alaska’s Medicaid program will reimburse for services “provided through the use of camera, video, or dedicated audio conference equipment on a real-time basis.”

Source: AK Admin. Code, Title 7, 110.625(a) (2012).

Alaska Medicaid will pay for a covered medical service furnished through telemedicine application if the service is:

- Covered under traditional, non-telemedicine methods;
- Provided by a treating, consulting, presenting or referring provider; and
- Appropriate for provision via telemedicine.


Medically necessary office consultations provided via telemedicine may be covered only when used as a second opinion and the provider is of a different specialty than the requesting provider. Documentation requirements apply.


Eligible services:

- Initial or one follow-up office visit;
- Consultation made to confirm diagnosis;
- A diagnostic, therapeutic or interpretive service;
- Psychiatric or substance abuse assessments;
- Individual psychotherapy or pharmacological management services.


No reimbursement for:

- Home and community-based waiver services;
- Pharmacy;
- Durable medical equipment;
- Transportation;
- Accommodation services;
- End-stage renal disease;
- Direct-entry midwife;
- Private duty nursing;
- Personal care assistants;
- Visual care, dispensing or optician services;
- Technological equipment and systems associated with telemedicine application.

Medicaid Telehealth Reimbursement

Eligible Providers

Office consultations performed by a provider of the same specialty within the same organization are not covered.


Eligible Sites

No reference found.

Geographic Limits

No reference found.

Facility/Transmission Fee

The department will pay only for professional services for a telemedicine application of service. The department will not pay for the use of technological equipment and systems associated with a telemedicine application to render the service.

Source: AK Admin. Code, Title 7, 110.635(b).

Community Behavioral Health Services

The department will pay a community behavioral health services provider for facilitation of a telemedicine session if:

- The Telemedicine communication equipment is supplied by the provider;
- The electronic connection used by the treating provider and the recipient are established and maintained by the provider;
- The provider remains available during the telemedicine session to reestablish failed connection before the intended end of the telemedicine session; and
- The provider documents in the recipient’s clinical record a note summarizing the facilitation of each telemedicine session (although the facilitating provider is not required to document a clinical problem or treatment goal as these are to be documented by the treating provider).

This service may be rendered to the following eligible recipients:

- Child or adult experiencing a substance use disorder or emotional disturbance
- Adult experiencing a serious mental illness

Source: AK Admin. Code, Title 7, 135.290.
## Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Store-and-Forward</th>
<th>Policy</th>
</tr>
</thead>
</table>

To be eligible for payment under store-and-forward the service must be “provided through the transference of digital images, sounds, or previously recorded video from one location to another to allow a consulting provider to obtain information, analyze it, and report back to the referring provider.”

Source: AK Admin. Code, Title 7, 110.625(a).

<table>
<thead>
<tr>
<th>Eligible Services/Specialties</th>
<th>No reference found.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Geographic Limits</th>
<th>No reference found.</th>
</tr>
</thead>
</table>

| Transmission Fee | The department will pay only for professional services for a telemedicine application of service. The department will not pay for the use of technological equipment and systems associated with a telemedicine application to render the service. |

Source: AK Admin. Code, Title 7, 110.635(b).

<table>
<thead>
<tr>
<th>Remote Patient Monitoring</th>
<th>Policy</th>
</tr>
</thead>
</table>

To be eligible for payment under self-monitoring or testing, “the services must be provided by a telemedicine application based in the recipient’s home, with the provider only indirectly involved in the provision of the service.”

Source: AK Admin. Code, Title 7, 110.625(a).
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conditions</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Provider Limitations</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Other Restrictions</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Remote Patient Monitoring</strong></td>
</tr>
<tr>
<td>No reimbursement for telephone.</td>
</tr>
<tr>
<td>No reimbursement for FAX.</td>
</tr>
<tr>
<td>Reimbursement for phone, only if part of a dedicated audio conference system. No reimbursement for FAX.</td>
</tr>
<tr>
<td><strong>Source:</strong> Source: AK Admin Code, Title 7, 110.625.</td>
</tr>
<tr>
<td><strong>Consent</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>
### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Out of State Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation requirements for telemedicine consultations include:</td>
</tr>
<tr>
<td>• Statement that the service was provided using telemedicine</td>
</tr>
<tr>
<td>• The address location of the patient</td>
</tr>
<tr>
<td>• The address location of the provider</td>
</tr>
<tr>
<td>• The method of telemedicine used</td>
</tr>
<tr>
<td>• The names of all persons participating in the telemedicine service and their role in the encounter</td>
</tr>
<tr>
<td>• The inquiry from the requesting provider</td>
</tr>
<tr>
<td>• The consulting provider’s report back to the requesting provider.</td>
</tr>
</tbody>
</table>


### Private Payer Laws

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private payers required to provide coverage for mental health benefits provided through telemedicine.</td>
</tr>
</tbody>
</table>

*Source: AK Statute, Sec. 21.54.102 (HB 234 – 2016).*

<table>
<thead>
<tr>
<th>Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>None.</td>
</tr>
<tr>
<td>Private Payer Laws</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Definitions</td>
</tr>
<tr>
<td>Consent</td>
</tr>
</tbody>
</table>
| Professional Regulation/Health & Safety | The guiding principles for telemedicine practice in the American Medical Association (AMA), Report 7 of the Council on Medical Service (A-14), Coverage of and Payment for Telemedicine, dated 2014, and the Federation of State Medical Boards (FSMB), Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine, dated April 2014, are adopted by reference as the standards of practice when providing treatment, rendering a diagnosis, prescribing, dispensing, or administering a prescription or controlled substance without first conducting an in-person physical examination.  
Source: AK 12 AAC 40.943. |
| Online Prescribing | A physician is not subject to disciplinary sanctions for rendering a diagnosis, treatment or prescribing a prescription drug (except a controlled substance) without a physical examination if the physician or another health care provider is available for follow up care and the physician requests that the person consent to sending a copy of all records of the encounter to the person’s primary care provider.  
The AK Medical Board is required to adopt regulations that establish guidelines for a physician who is rendering a diagnosis, treatment or prescribing without conducting a physical exam.  
Source: AK Statute, Sec. 08.64.364 (SB 74 – 2016).  
Physicians are prohibited from prescribing medications based solely on a patient-supplied history received by telephone, FAX, or electronic format  
Source: AK Admin. Code, Title 12, Sec. 40.967. |
<table>
<thead>
<tr>
<th>Professional Regulation/Health &amp; Safety</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-State Licensing</td>
<td>No reference found.</td>
<td></td>
</tr>
</tbody>
</table>

The Department of Commerce, Community and Economic Development is required to adopt regulations for establishing and maintaining a registry of businesses performing telemedicine in the state.

**Source:** AK Statute, Sec. 44.33.381. (SB 74 – 2016).

See business registry regulations for more details.

**Source:** AK Admin Code. Sec. 600, Article 5.

**Professional Board Telehealth-Specific Regulations**

- Medical Board (**Source:** AK 12 AAC 40.943).
Arizona Medicaid Program: Arizona Health Care Cost Containment System (AHCCCS)
Program Administrator: Arizona Health Care Cost Containment System Administration
Regional Telehealth Resource Center: Southwest Telehealth Resource Center
Covers the States of: Arizona, Colorado, Nevada, New Mexico, and Utah
www.southwesttrc.org

Arizona Health Care Cost Containment System (AHCCCS) reimburses for live video for certain services delivered at specific originating sites by specific providers. They reimburse for store-and-forward for specific specialties and for remote patient monitoring for patients with chronic heart failure. Restrictions apply for all the above.

All services provided via telemedicine must be reasonable, cost effective and medically appropriate. Services are billed by the consulting provider. Tele-presenter services are not billable.


Service delivery via telemedicine can be in one of two models: Real time means the interactive, two-way transfer of information and medical data, which occurs at two sites simultaneously: the hub site and spoke site … Diagnostic, consultation and treatment services are delivered through interactive, audio, video and/or communication. Store-and-forward means transferring medical data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.


Telemedicine is “the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the member, including audio or video communications sent to a health care provider for diagnostic or treatment consultation.”

Telehealth (or telemonitoring) is “the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote member monitoring devices, which are used to collect and transmit member data for monitoring and interpretation. While they do not meet the Medicaid definition of telemedicine they are often considered under the broad umbrella of telehealth services. Even though such technologies are not considered telemedicine, they may nevertheless be covered service.”


Telemedicine means the practice of health care delivery, diagnosis, consultation, and treatment and the transfer of medical data through interactive audio, video, and data communications that occur in the physical presence of the patient.

Medicaid Telehealth Reimbursement

Fee for Service Provider Manual
AHCCCS will reimburse for medically necessary services provided via live video in their fee for service program.


Eligible services:

• Cardiology;
• Dermatology;
• Endocrinology;
• Hematology/oncology;
• Home Health
• Infectious diseases;
• Neurology;
• Obstetrics/gynecology;
• Oncology/radiation;
• Ophthalmology;
• Orthopedics;
• Pain clinic;
• Pathology;
• Pediatrics and pediatric sub-specialties;
• Radiology;
• Rheumatology;
• Surgery follow-up and consults;
• Behavioral health services
  1. Diagnostic consultation and evaluation;
  2. Psychotropic medication adjustment and monitoring;
  3. Individual and family counseling;
  4. Case management


Additional Covered Services (listed in Telehealth Policy)

• Behavioral Health
• Inpatient consultation
• Medical Nutrition Therapy (MTN)
• Office, outpatient, and surgery follow-up-consultations
• Pain management
• Pharmacy management

Telehealth policy lists covered codes.


Behavioral health services are covered for AHCCS and KidsCare patients.

Covered behavioral health services:

• Diagnostic consultation and evaluation;
• Psychotropic medication adjustment and monitoring;
• Individual and family counseling;
• Case management.

AHCCCS covers real-time teledentistry for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members when provided by a registered dental providers.


Teledentistry services will be reimbursed for enrollees under the age of 21.

Source: AZ Statute, Sec. 36.1.

Eligible Providers

- Physician
- Registered nurse practitioner
- Physician assistant
- Certified nurse midwife
- Clinical psychologist
- Licensed clinical social worker
- Licensed marriage and family therapist
- Licensed professional counselor

Out-of-state providers may provide and bill for spoke and/or hub telehealth services.


The patient’s primary care provider (PCP), attending physician, other medical professional employed by the PCP, or an attending physician who is familiar with the patient’s condition may be present.

Other medical professionals:

- Registered nurses;
- Licensed practical nurses;
- Clinical nurse specialists;
- Registered nurse midwives;
- Registered nurse practitioners;
- Physician assistants;
- Physical, occupational, speech, and respiratory therapists;
- Trained telepresenter familiar with the recipient’s medical condition.


Eligible hub or spoke sites for Indian Health Services or tribal providers:

- Indian Health Service clinic;
- Tribally-governed facility;
- Urban clinic for American Indians;
- Physician or other provider office;
- Hospital;
- Federally Qualified Health Center (FQHC).


Fee for service manual definitions:

Hub site – “the location of the telemedicine consulting provider, which is considered the place of service.”

Spoke site – “the location where the recipient is receiving the telemedicine service.”

## Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Live Video</th>
<th>Geographic Limits</th>
</tr>
</thead>
</table>
| Facility/Transmission Fee | A facility fee is not an AHCCCS covered service.  

<table>
<thead>
<tr>
<th>Store-and-Forward</th>
<th>Policy</th>
</tr>
</thead>
</table>
| AHCCCS will reimburse for store-and-forward in their fee-for-service program.  

The same services are covered for store-and-forward, as for real time, except for the field of Behavioral Health Services.

Real time telemedicine is the only type of reimbursement available in the field of Behavioral Health Services.


AHCCCS only covers store-and-forward for (and is subject for review) the following:

- Dermatology
- Radiology
- Ophthalmology
- Pathology

AHCCCS does not consider asynchronous or “store-and-forward” applications to be telemedicine, but it may be utilized to deliver services.

Medicaid Telehealth Reimbursement

### Store-and-Forward

The following exceptions may be eligible for reimbursement, but are not considered a “telemedicine service”:

- A provider in the role of tele-presenter may be providing a separately billable service, such as an electrocardiogram or an X-ray. The service is covered, but not the tele-presenting.
- A consulting distant-site provider may offer a service that does not require real-time patient interaction. Reimbursement only for dermatology, radiology, ophthalmology, and pathology. It is subject to review by AHCCCS Medical Management.
- When a patient in a rural area presents within three hours of onset of stroke symptoms, AHCCCS will reimburse the consulting neurologist if the consult is placed for assistance in determining appropriateness of thrombolytic therapy even when the patients’ condition is such that real-time video interaction cannot be achieved.
- Additional exceptions for Behavioral Services apply.


### Geographic Limits

No reference found.

### Transmission Fee

No reference found.

### Telemonitoring

Telemonitoring is considered necessary for members with Congestive Heart Failure (CHF).


### Conditions

The following conditions must be met for Congestive Heart Failure (CHF) patients:

- Observation/inpatient admission with primary or secondary discharge diagnosis of CHF within the past two months, or readmission within the past six months; AND
- A symptom level at the New York Heart Association class II or greater; CHF is identified by one of the specified ICD-10 diagnostic codes (see manual).

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider Limitations</strong></td>
<td></td>
</tr>
<tr>
<td>Other limitations apply. See manual.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Remote Patient Monitoring</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Email / Phone / Fax</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Consent</strong></td>
<td></td>
</tr>
<tr>
<td>If there will be a recording of the interactive video service, a separate consent must be obtained. See manual for full requirements.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out of State Providers</strong></td>
<td></td>
</tr>
<tr>
<td>For teledentistry services: A consultation by a non-Arizona licensed provider may occur if:</td>
<td></td>
</tr>
<tr>
<td>• It is to a specific patient in the AHCCCS program;</td>
<td></td>
</tr>
<tr>
<td>• The provider is registered with AHCCCS;</td>
<td></td>
</tr>
<tr>
<td>• The provider is licensed in the state the consultation is being provided from, or the provider is employed by an Indian Health Services, Tribal or Urban Indian Health program and appropriately licensed based on IHS and Tribal facility requirements.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No reference found.
<table>
<thead>
<tr>
<th>Private Payer Laws</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definitions</strong></td>
<td></td>
</tr>
<tr>
<td>“Telemedicine means the interactive use of audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Does not include the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail.”</td>
<td>Source: AZ Statute 20-841.09.</td>
</tr>
<tr>
<td>Under State Administrative Code, Department of Insurance, Health Care Services Organizations Oversight, “telemedicine means diagnostic, consultation, and treatment services that occur in the physical presence of an enrollee on a real-time basis through interactive audio, video, or data communication.”</td>
<td>Source: AZ Admin. Code Sec. R20-6-1902.</td>
</tr>
<tr>
<td><strong>Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>Health Care Service Organizations (HCSO) must provide coverage for specified health care services that are provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the enrollee and a health care provider and provided to an enrollee receiving the service in Arizona. Only applies to specific conditions and settings.</td>
<td>Source: AZ Rev. Statues. Sec. 20-841.09.</td>
</tr>
<tr>
<td>Health Care Service Organizations (HCSO) are allowed, but not mandated, to provide access to covered services through telemedicine, telephone, and email.</td>
<td>Source: AZ Admin. Code Sec. R20-6-1915.</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
</tr>
<tr>
<td>No parity. Requirement for telehealth coverage only applies to the following conditions and settings:</td>
<td></td>
</tr>
<tr>
<td>• Trauma</td>
<td></td>
</tr>
<tr>
<td>• Burn</td>
<td></td>
</tr>
<tr>
<td>• Cardiology</td>
<td></td>
</tr>
<tr>
<td>• Infectious diseases</td>
<td></td>
</tr>
<tr>
<td>• Mental health disorders</td>
<td></td>
</tr>
<tr>
<td>• Neurologic diseases including strokes</td>
<td></td>
</tr>
<tr>
<td>• Dermatology</td>
<td></td>
</tr>
<tr>
<td>• Pulmonology</td>
<td></td>
</tr>
<tr>
<td>• Urology (Eff. Jan. 2020)</td>
<td></td>
</tr>
<tr>
<td>• Substance Abuse (Eff. Jan. 2019)</td>
<td></td>
</tr>
<tr>
<td>Source: AZ Rev. Statues. Sec. 20-841.09.</td>
<td></td>
</tr>
<tr>
<td><strong>Payment Parity</strong></td>
<td></td>
</tr>
<tr>
<td>None.</td>
<td></td>
</tr>
</tbody>
</table>
### Definitions

Under Arizona Statute, Public Health & Safety, “telemedicine means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the patient, including audio or video communications sent to a health care provider for diagnostic or treatment consultation.”

*Source: AZ Revised Statute Sec. 36-3601.*

Under the Board of Behavioral health, “telepractice” means providing behavioral health services through interactive audio, video or electronic communication that occurs between the behavioral health professional and the client, including any electronic communication for evaluation, diagnosis and treatment, including distance counseling, in a secure platform, and that meets the requirements of telemedicine pursuant to section 36-3602.

*Source: AZ Revised Statute Sec. 32-3251(15) (2015).*

### Consent

Providers must obtain and document oral or written consent before delivery of services. Oral consent should be documented on the patient’s medical record.

*Source: AZ Revised Statute Sec. 36-3602 (2012).*

### Online Prescribing

Physicians are prohibited from issuing a prescription to patients without having a physical or mental health status examination to establish a provider-patient relationship.

The physical or mental health status examination can be conducted during a real-time telemedicine encounter.

*Source: Arizona Revised Statute Sec. 32-1401 (SB 1339).*

### Cross State Licensing

AZ enacted the Interstate Medical Licensure Compact.

*Source: ARS Sec. 32-3241.*

An out-of-state doctor may engage in a single or infrequent consultation with an Arizona physician.

*Source: AZ Revised Statute Sec. 32-1421.*

Arizona adopted the interjurisdictional Compact of the Association of State and Provincial Psychology Boards (PSYPACT). (The Compact becomes effective 1/1/2020 unless a seventh state enacts the Compact before then).

*Source: HB 2503 (2016).*

Member of Nurse Licensure Compact.


Member of Physical Therapy Compact.

*Source: HB2504 (2016). PT Compact.*
Arizona explicitly prohibits the use of telemedicine to provide an abortion.

Source: AZ Revised Statute Sec. 36-3604 (2012).

Professional regulation with telehealth specific standards

- Board of Psychologist Examiners (Source: AAZ Reg. Sec. R4-26-109).
Arkansas Medicaid reimburses for live video when the telemedicine service is comparable to an in-person service. Store-and-forward and remote patient monitoring is included in Medicaid’s definition of telemedicine, but there was no specific information found regarding reimbursement of the modalities.

Definitions

Telemedicine is defined as the use of electronic information and communication technology to deliver healthcare services including without limitation, the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient. Telemedicine includes store-and-forward technology and remote patient monitoring.

Store-and-forward technology is the transmission of a patient’s medical information from a healthcare provider at an originating site to a healthcare provider at a distant site. Remote patient monitoring means the use of electronic information and communication technology to collect personal health information and medical data from a patient at an originating site that is transmitted to a healthcare provider at a distant site for use in the treatment and management of medical conditions that require frequent monitoring.

Rural Health Centers

Arkansas Medicaid defines telemedicine services as medical services performed as electronic transactions in real-time.

Telemedicine means the use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient. Telemedicine includes store-and-forward and remote patient monitoring. Telemedicine does not include the use of audio-only communication including without limitation interactive audio; a facsimile machine; text messaging; or electronic mail systems.

Arkansas Medicaid provides payment to a licensed or certified healthcare professional or a licensed or certified entity for services provided through telemedicine if the service provided through telemedicine is comparable to the same service provided in-person.

Coverage and reimbursement for services provided through telemedicine will be on the same basis as for services provided in-person. While a distant site facility fee is not authorized under the Telemedicine Act, if reimbursement includes payment to an originating site (as outlined in the above paragraph), the combined amount of reimbursement to the originating and distant sites may not be less than the total amount allowed for healthcare services provided in-person.


### Rural Health Centers

In order for a telemedicine encounter to be covered by Medicaid, the practitioner and the patient must be able to see and hear each other in real time.


Arkansas Medicaid must provide coverage and reimbursement for healthcare services provided through telemedicine on the same basis as they provide coverage and reimbursement for health services provided in-person. They are not required to reimburse for healthcare services provided through telemedicine that are not comparable to the same service provided in-person.

**Source:** AR Code 23-79-1602.

Telemedicine is listed as an allowed delivery mode under the Outpatient Behavioral Health Services manual.


### Rural Health Centers

Arkansas Medicaid covers RHC encounters and two ancillary services (fetal echography and echocardiology) as "telemedicine services". Physician interpretation of fetal ultrasound is covered as a telemedicine service if the physician views the echography or echocardiography output in real time while the patient is undergoing the procedure.


The professional or entity at the distant site must be an enrolled Arkansas Medicaid Provider.


The distant site provider should use the GT modifier and Place of Service 02 when billing CPT or HCPCS codes.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th><strong>Eligible Sites</strong></th>
<th>No reference found.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Geographic Limits</strong></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
|                                 | **Live Video**     | Payment will include a reasonable facility fee to the originating site operated by a licensed or certified healthcare professional or licensed or certified healthcare entity if the professional or entity is authorized to bill Arkansas Medicaid directly for healthcare services.  


The originating site submits a telemedicine claim under the billing providers “pay to” information using HCPCS code Q3014. In the case of in-patient services, HCPCS code Q3014 is not separately reimbursable because it is included in the hospital per diem. See manual for further instructions. 


**Federally Qualified Health Centers**  
Use procedure code T1014 to indicate telemedicine charges. The charge associated with the procedure code should be an amount attributable to the telemedicine service, such as line (or wireless) charges. Medicaid will deny the charge and capture it in the same manner as with ancillary charges.  


Arkansas Medicaid must provide a reasonable facility fee to an originating site operated by a licensed healthcare entity or healthcare professional.  

**Source:** AR Code 23-79-1602(d) (3). |
<p>|                                 | <strong>Facility/Transmission Fee</strong> | |
|                                 | <strong>Store-and-Forward</strong> | Although store-and-forward is included in Medicaid’s definition of telemedicine, no information was found regarding reimbursement of store-and-forward. |</p>
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Store-and-Forward</th>
<th>Geographic Limits</th>
<th>Eligible Services/Specialties</th>
<th>Transmission Fee</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote Patient Monitoring</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Although remote patient monitoring is included in Medicaid’s definition of telemedicine, no information was found regarding reimbursement of remote patient monitoring.
Once a professional relationship is established, the healthcare provider may provide healthcare services through telemedicine, including interactive audio, if the healthcare services are within the scope of practice for which the healthcare provider is licensed or certified and in accordance with the safeguards established by the healthcare professionals licensing board. The use of interactive audio is not reimbursable under Arkansas Medicaid.


A provider must obtain informed consent, as required by applicable state and federal laws, rules and regulations.


A healthcare provider treating patients in Arkansas through telemedicine shall be fully licensed or certified to practice in Arkansas and is subject to the rules of the appropriate state licensing or certification board. This requirement does not apply to the acts of a healthcare provider located in another jurisdiction who provides only episodic consultation services.


The distant site provider is prohibited from utilizing telemedicine with a patient unless a professional relationship exists between the provider and patient. See manual for ways to establish the relationship. A professional relationship is established if the provider performs a face-to-face examination using real time audio and visual telemedicine technology that provides information at least equal to such information as would have been obtained by an in-person examination; or if the establishment of a professional relationship is permitted via telemedicine under the guidelines outlined in ASMB regulations. Telemedicine may be used to establish the professional relationship only for situations in which the standard of care does not require an in-person encounter and only under the safeguards established by the healthcare professional’s licensing board (See ASMB Regulation 38 for these safeguards including the standards of care). See manual for full list of requirements on establishing a professional relationship. Special requirements also exist for providing telemedicine services to a minor in a school setting (see manual).

A healthcare provider providing telemedicine services within Arkansas shall follow applicable state and federal laws, rules and regulations regarding:

- Informed consent;
- Privacy of individually identifiable health information;
- Medical record keeping and confidentiality, and
- Fraud and abuse.

| Definitions | Telemedicine means the use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient. Telemedicine includes store-and-forward and remote patient monitoring. Telemedicine does not include the use of audio-only communication including without limitation interactive audio; a facsimile machine; text messaging; or electronic mail systems.  
**Source:** AR Code 23-79-1601(7). |
|---|---|
| Requirements | A health plan shall cover the telehealth-delivered healthcare services on the same basis it would if the services were delivered in-person. A health benefit plan is not required to reimburse for a healthcare service provided through telemedicine that is not comparable to the same service provided in-person. A health benefit plan may voluntarily reimburse for healthcare services provided through means of telephone, facsimile, text message or electronic mail.  
A healthcare plan must provide a reasonable facility fee to an originating site operated by a healthcare professional or licensed healthcare entity if licensed to bill the health benefit plan.  
A health benefit plan cannot prohibit its providers from charging patients directly for telephone calls that aren’t reimbursed by the plan.  
A health plan may not impose:  
- An annual or lifetime dollar maximum on coverage for services provided through telemedicine unless it applies to the aggregate of all items and services covered  
- A deductible, copayment, coinsurance, benefit limitation or maximum benefit that is not equally imposed upon other healthcare services; or  
- A prior authorization requirement that exceeds the requirements for in-person healthcare services.  
**Source:** AR Code Sec. 23-79-1602. |
| Parity | Health plans must reimburse “on the same basis” if the service were delivered in-person. A health benefit plan is not required to reimburse for a healthcare service provided through telemedicine that is not comparable to the same service provided in-person.  
**Source:** AR Code 23-79-1602. |
| Payment Parity | The combined amount of reimbursement that a health benefit plan allows for the compensation to the distant site and the originating site shall not be less than the total amount allowed for healthcare services provided in-person.  
**Source:** AR Code 23-79-1602. |
### Definitions

“Telemedicine means the use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient. Telemedicine includes store-and-forward technology and remote patient monitoring.”

**Source:** AR Code Sec. 17-80-402.

The Board of Examiners in Speech-Language Pathology and Audiology defines “telepractice” as tele-speech, teleaudiology, teleSLP, telehealth or telerehabilitation when used separately or together.

It defines “telepractice service” as the application of telecommunication technology equivalent in quality to services delivered face-to-face to deliver speech-language pathology or audiology services, or both, at a distance for assessment, intervention or consultation, or both.

**Source:** AR Code Sec. 17-100-103.

### Consent

The healthcare professional shall follow applicable state and federal laws, rules and regulations for informed consent.

**Source:** AR Code 17-80-404.

### Online Prescribing

A distant site provider will not utilize telemedicine to treat a patient located in Arkansas unless a professional relationship exists between the healthcare provider and the patient or as otherwise meets the definition of a professional relationship as defined in Section 17-80-402. Existence of a professional relationship is not required in the following circumstances:

- Emergency situations where life or health of the patient is in danger or imminent danger or
- Simply providing information in a generic nature not meant to be specific to an individual patient.

**Source:** AR Code 17-80-402.

A proper physician or physician assistant/patient relationship can be established via real time audio and video telemedicine.

**Source:** AR Rules and Regulation. Sec. 060.00.16.

A patient completing a medical history online and forwarding it to a physician is not sufficient to establish the relationship, nor does it qualify as store-and-forward technology.

A physician may not use telemedicine to issue a prescription for a controlled substance under schedules II through V unless they have seen the patient in-person or a relationship exists through consultation or referral; on-call or cross coverage situations; or through an ongoing personal or professional relationship.

**Source:** AR Rules and Regulation. Sec. 060.00.16. Reg. 38, codified in ACA Sec. 17-80-117.

When abortion inducing drugs are used, the initial administration must occur in the same room and in the physical presence of the prescribing physician.

**Source:** AR Rules and Regulation. Sec. 060.00.16.
Without a prior and proper patient-provider relationship, providers are prohibited from issuing prescriptions solely in response to an Internet questionnaire, an Internet consult, or a telephone consult.


Under specified circumstances, the standard of care must not require an in-person encounter. A professional relationship cannot be established only through:

- An internet questionnaire
- Email message
- Patient generated medical history
- Audio only communication, including without limitation interactive audio
- Text messaging
- Facsimile machine
- Any combination thereof


A written medical marijuana certification is not allowed when an assessment is performed through telemedicine.


Arkansas prohibits the use of telemedicine to administer drugs that provide medical abortions.


An out-of-state physician utilizing an electronic medium who performs an act that is part of a patient care service that was initiated in Arkansas, including interpretation of an X-ray, that would affect the diagnosis or treatment, is engaged in the practice of medicine and subject to regulation by the Arkansas State Medical Board.


Healthcare providers must be fully licensed or certified in Arkansas to provide services in the state unless the out-of-state provider is only providing episodic consultation services.


AR Medical Board required to perform an analysis of the Interstate Medical Licensure Compact to determine whether the State of AR should participate.

Source: SB 78 (2017).

Member of Nurse Licensure Compact.


Professional Telehealth-Specific Regulations

- AR Board of Examiners in Speech-Language Pathology and Audiology
  Source: Rules and Regulations Board of Examiners in Speech-Language Pathology and Audiology, Sec. 12.

- AR Board of Nursing: Advanced Practice Registered Nurse
  Source: Rule 67.00.17-005, Sec 14.
### Summary

Medi-Cal reimburses for a limited set of services via live video. Specific CPT/HCPCS codes are outlined in the Medi-Cal manual. Medi-Cal will also reimburse store-and-forward for teledermatology, tele-ophthalmology and teledentistry for certain CPT/HCPCS codes.

### Definitions

**Telehealth** [according to the Telehealth Advancement Act of 2011] “is the mode of delivering health care services and public health utilizing information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at the distant site.”

“Telemedicine [according to CMS] is the use of medical information exchanged from one site to another using interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between the patient and physician or practitioner at the distant site to improve a patient’s health. Medi-Cal uses the term telemedicine when it makes a distinction from telehealth.”


### Live Video Policy

Medi-Cal will reimbursement for services provided via live video. Services must be billed with modifiers GT or 95.


Medi-Cal will reimburse for services provided via live video.

**Source:** Sec. 14132.72 of the Welfare and Institutions Code.

For Denti-Cal, live transmissions are only billable if the beneficiary requests it.

**Source:** Denti-Cal Provider Handbook. (4-13 to 4-15). (Sept. 2018).
### Medicaid Telehealth Reimbursement

#### Eligible Services / Specialties

Specific eligible CPT/HCPCS codes are provided in Medi-Cal and Denti-Cal manuals.


CA Children’s Services Program lists eligible CPT/HCPCS codes in Numbered Letters 16-1217 & 09-0718. Codes specifically include tele-speech, tele-auditory verbal therapy, tele-auditory habilitation and tele-auditory rehabilitation services in the home, with the parent or guardian working with the speech therapist at the distant site.


#### Eligible Providers

Allied dental professionals are not permitted to bill for teledentistry.

**Source:** Denti-Cal Provider Handbook. (4-13 to 4-15). (Apr. 2018).

#### Eligible Sites

The type of setting where services are provided is not limited.


CA Children’s Services Program lists eligible CPT/HCPCS codes related to tele-speech, tele-auditory verbal therapy, tele-auditory habilitation and tele-auditory rehabilitation services in the home, with the parent or guardian working with the speech therapist at the distant site.


#### Geographic Limits

No reference found.

#### Facility/Transmission Fee

Medi-Cal will reimburse the originating site a facility fees, and originating and distant site for live video transmission costs.

<table>
<thead>
<tr>
<th>Store-and-forward</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal will reimburse for store-and-forward services for certain specialties.</td>
<td>Source: Sec. 14132.725 of the Welfare and Institutions Code.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligible Services/Specialties</th>
<th>Policy</th>
</tr>
</thead>
</table>
| Eligible specialties include tele-dermatology, tele-ophthalmology and teledentistry. | See Medi-Cal and Denti-Cal manual for eligible codes.  

<table>
<thead>
<tr>
<th>Geographic Limits</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transmission Fee</th>
<th>Policy</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Remote Patient Monitoring</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Limitations</strong></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td><strong>Other Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td><strong>Email / Phone / Fax</strong></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal does not reimburse for telephone calls, electronic mail messages or facsimile transmissions.</td>
<td></td>
</tr>
<tr>
<td><strong>Consent</strong></td>
<td></td>
</tr>
<tr>
<td>Provider must obtain oral consent from the patient and document it in the patient record.</td>
<td></td>
</tr>
<tr>
<td><strong>Out of State Providers</strong></td>
<td></td>
</tr>
<tr>
<td>For rules pertaining to out-of-state providers, see Medi-Cal’s Out-of-State providers FAQs.</td>
<td></td>
</tr>
</tbody>
</table>
### Medicaid Telehealth Reimbursement

Medi-Cal covers telehealth to the extent services are allowable and reimbursed according to the department’s telehealth manual in the California Children’s Services Program (CCS), Genetically Handicapped Person’s Program (GHPP) and Child Health and Disability Prevention Program (CHDP).

**Source:** CA Department of Health Care Services, Medi-Cal Special Programs FAQs. (Accessed Sept. 2018).

Telehealth services and supports are among the services and supports authorized to be included by individual program plans developed for disabled individuals by regional centers that contract with the State Department of Developmental Disabilities.

**Source:** Welfare and Institutions Code Sec. 4512.

Medicaid must ensure that all managed care covered services are available and accessible to enrollees of Medicaid managed care plans in a timely manner. Telecommunications technologies can be used as a means to meet time and distance standards in some circumstances. See regulation for details.

**Source:** CA Welfare and Institutions Code Sec. 14197.

### Definitions

“Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store-and-forward transfers.”

**Source:** CA Business & Professions Code Sec. 2290.5.

### Requirements

Private payers cannot require that in-person contact occur before payment is made for covered telehealth services, subject to contract terms and conditions. Health plans cannot limit the settings where services are provided. Settings are still subject to contract terms and conditions.

**Source:** CA Health & Safety Code Sec. 1374.13.

Private payers cannot require that in-person contact occur before covering a telehealth delivered service, but it is subject to the terms and conditions of the contract.

**Source:** CA Health & Safety Code Sec. 1374.13.

### Parity

No explicit payment parity.
Definitions

“Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store-and-forward transfers.”

Source: CA Business & Professions Code Sec. 2290.5.

Consent

The originating site provider must obtain and document verbal or written patient consent prior to service delivery.

Source: CA Business & Professions Code Sec. 2290.5.

Occupational Therapy

Informed consent must be obtained by the occupational therapist prior to the use of telehealth to deliver services.

Source: CA Code of Regulations, Title 16, Div. 39, Art. 8, Sec. 4172.

Behavioral Sciences

A licensee must obtain informed consent from a client.

Source: CA Code of Regulations, Title 16, Div. 18, Art. 1, Sec. 1815.5.

Online Prescribing

Providers are prohibited from prescribing or dispensing dangerous drugs or dangerous devices on the Internet without an appropriate prior examination and medical indication.

Source: CA Business & Professions Code Sec. 2242.1(a).

Remote Dispensing Site Pharmacies

Remote dispensing site pharmacies are permitted to dispense or provide pharmaceutical care services in medically underserved areas. A supervising pharmacy must provide telepharmacy services to the remote dispensing site pharmacy and shall not be located greater than 150 road miles from the remote dispensing site pharmacy.

Source: CA Business & Professionals Code Sec. 4130-4135.

Cross-State Licensing

No reference found.

Miscellaneous

Professional regulation with telehealth specific standards

- CA Board of Occupational Therapy (Source: Title 16, Div. 39, Sec. 4172).
- CA Board of Behavioral Sciences (Source: Title 16, Div. 18, Art. 1, Sec. 1815.5).
Colorado Medicaid reimburses for live video for medical and mental health services. They also provide reimbursement for remote patient monitoring for patients with certain chronic conditions. Colorado Medicaid requires a member to be present and participating in a telemedicine service, excluding the possibility of utilizing store-and-forward.

<table>
<thead>
<tr>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine is not a unique service, but a means of providing selected services approved by Health First Colorado through live interactive audio and video telecommunications equipment.</td>
</tr>
</tbody>
</table>


Telehealth services include the installation and on-going remote monitoring of clinical data through technologic equipment in order to detect minute changes in the client’s clinical status that will allow Home Health agencies to intercede before a chronic illness exacerbates requiring emergency intervention or inpatient hospitalization.


Telehealth allows for the monitoring of a member’s health status remotely via equipment, which transmits data from the member’s home to the member’s home health agency. The purpose of providing telehealth services is to assist in the effective management and monitoring of members whose medical needs can be appropriately and cost-effectively met at home through the frequent monitoring of data and early intervention.


<table>
<thead>
<tr>
<th>Live Video</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO Medicaid will cover telemedicine direct member services which can involve up to two collaborating providers and the member. It is also acceptable for an originating provider not to be present, as long as the telecommunication equipment facilitates live contact between a member and a distant provider.</td>
</tr>
</tbody>
</table>


Services shall be subject to reimbursement policies developed by the medical assistance program. Reimbursement must be the same as in-person services.

**Source:** CO Revised Statutes 25.5-5-320.
Colorado Medicaid will reimburse for medical and mental health services.

Source: CO Revised Statutes 25.5-5-320.

A primary care provider (PCP) is eligible to be reimbursed as the ‘originating provider’. In order for a PCP to be reimbursed as a distant provider, the PCP must be able to facilitate an in-person visit in the state of CO if necessary for treatment of the member’s condition.

A specialist is eligible to be an originating provider or distant provider.


If no originating provider is present, then the location of the originating site is at the member’s discretion and can include the member’s home.


No reference found.

The originating site is eligible for a facility fee.

Providers eligible for the originating site facility fee include:

- Physician
- Clinic
- Osteopath
- FQHC
- Doctorate Psychologist
- MA Psychologist
- Physician Assistant
- Nurse Practitioner

Other sites can serve as an originating site, but cannot collect the facility fee.

Using modifier GT adds $5.00 to the procedure code billed for the service for distant site providers for the transmission fee. A specific list of eligible codes is provided in the manual. Other codes can be billed, but don’t pay the telemedicine transmission fee.


The CO Medical Assistance Program will reimburse for transmission costs, at a rate set by their state department.

Source: CO Revised Statutes 25.5-6-320.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Store-and-Forward</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The member must be present during any Telemedicine Direct Member Services that involve two collaborating providers.</td>
</tr>
</tbody>
</table>

| Eligible Services/Specialties | | No reference found. |
|------------------------------| | |

| Geographic Limits | | No reference found. |
|-------------------| | |

| Transmission Fee | | No reference found. |
|------------------| | |

<table>
<thead>
<tr>
<th>Remote Patient Monitoring</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The CO Medical Assistance Program will reimburse for Remote Patient Monitoring at a flat fee set by the state board.</td>
</tr>
<tr>
<td></td>
<td>Source: (Reimbursement): CO Revised Statutes 25.5-5-321.</td>
</tr>
<tr>
<td></td>
<td>Source: (Requirements): 10 CO Code of Regulation 2505-10 8.524.</td>
</tr>
<tr>
<td></td>
<td>CO Medicaid reimburses telehealth monitoring for qualified clients (see requirements below).</td>
</tr>
<tr>
<td><strong>Medicaid Telehealth Reimbursement</strong></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Remote Patient Monitoring</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Conditions</strong></td>
<td></td>
</tr>
<tr>
<td>The following requirements must be met:</td>
<td></td>
</tr>
<tr>
<td>• The patient is receiving services from a home health provider for at least one of the following: congestive heart failure, chronic obstructive pulmonary disease, asthma, or diabetes;</td>
<td></td>
</tr>
<tr>
<td>• The patient requires monitoring at least five times weekly to manage the disease, as ordered by a physician or podiatrist;</td>
<td></td>
</tr>
<tr>
<td>• The patient has been hospitalized two or more times in the last 12 months for conditions related to the disease;</td>
<td></td>
</tr>
<tr>
<td>• The patient or caregiver misses no more than five monitoring events in a 30-day period;</td>
<td></td>
</tr>
<tr>
<td>• The patient’s home has space for all program equipment and full transmission capability.</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Limitations</strong></td>
<td></td>
</tr>
<tr>
<td>Acute home health agencies and long-term home health agencies are reimbursed for the initial installation and education of telehealth monitoring equipment and can be billed once per client per agency. The agency can also bill for every day they receive and review the client’s clinical information.</td>
<td></td>
</tr>
<tr>
<td>No prior authorization needed, but agencies should notify the Department or its designee when a client is enrolled in the service.</td>
<td></td>
</tr>
<tr>
<td><strong>Other Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td>Additional restrictions apply. See Colorado Code of Regulations for more information.</td>
<td></td>
</tr>
<tr>
<td>Medicaid Home Health will reimburse for services only if the patient has no other insurance.</td>
<td></td>
</tr>
<tr>
<td><strong>Source:</strong> 10 CO Code of Regulation 2505-10 8.524.</td>
<td></td>
</tr>
<tr>
<td><strong>Email / Phone / Fax</strong></td>
<td></td>
</tr>
<tr>
<td>No reimbursement for telephone.</td>
<td></td>
</tr>
<tr>
<td>No reimbursement for FAX.</td>
<td></td>
</tr>
</tbody>
</table>
### Medicaid Telehealth Reimbursement

The Medicaid requirement for face-to-face contact between provider and member may be waived prior to treating the member through telemedicine for the first time. The rendering provider must furnish each member with all of the following written statements which must be signed by the member or the member’s legal representative:

- The member retains the option to refuse the delivery of health care services via telemedicine at any time without affecting the member’s right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the member would otherwise be entitled.
- All applicable confidentiality protections shall apply to the services.
- The member shall have access to all medical information resulting from the telemedicine services as provided by applicable law for client access to his or her medical records.

These requirements do not apply in an emergency.


### Out of State Providers

No reference found.

### Miscellaneous

Managed care may or may not reimburse telemedicine costs.


Provider of telemedicine services are required to implement certain confidentiality procedures.


Costs and salaries associated with telemedicine visits at an FQHC are included in the cost report and are not billable encounters. The services are reimbursed through the prospective payment system.

**Source:** CO Department of Health Care Policy and Financing. “Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)” (Accessed Sept. 2018).

### Private Payer Laws

Telehealth means a mode of delivery of healthcare services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a covered person’s health care while the covered person is located at an originating site and the provider is located at a distant site. The term includes synchronous interactions, store-and-forward transfers and services provided through HIPAA Compliant interactive audio visual communication or the use of a HIPAA compliant application via a cellular telephone. Telehealth does not include the delivery of health care services via voice only telephone communication or text messaging, facsimile machine or electronic mail.

**Source:** CO Revised Statutes 10-16-123(2) (h) (4) (e) (I & II).
A health benefit plan that is issued, amended or renewed shall not restrict or deny coverage solely because the service is provided through telehealth or based on the communication technology or application used to deliver the telehealth services, subject to the terms and conditions of the plan. A health plan is not required to pay for consultation provided by a provider by telephone or facsimile unless the consultation is provided through HIPAA compliant interactive audio-visual communication or the use of a HIPAA compliant application via a cellular telephone.

A carrier shall include in the payment for telehealth interactions reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services through telehealth except for when the originating site is a private residence.

Source: CO Revised Statutes 10-16-123.

CO insurers cannot deny coverage solely because the service is provided through telehealth. However, use of the word solely, may mean they can find other reasons, such as the service doesn’t meet the appropriate standard of care in the insurer’s view.

No explicit payment parity.

“Telehealth” means a mode of delivery of health care services through telecommunication systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education and care management of a resident’s health care when the resident and practitioner are located at different sites. Telehealth includes ‘telemedicine’ as defined in Section 12-36-102.5(8), C.R.S.”

Source: 6 CO Regs. Rule 1011-1. Ch. 5.

“Telemedicine means the delivery of medical services and any diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication.”

Source: CO Revised Statutes 12-36-102.5.

Providers shall give all first-time patients a written statement that includes the following:

- The patient may refuse telemedicine services at any time, without loss or withdrawal of treatment;
- All applicable confidentiality protections shall apply to the services;
- The patient shall have access to all medical information from the services, under state law.

Source: CO Revised Statutes 25.5-5-320.

Workers’ Compensation

The patient needs to give consent.

Online Prescribing

Pharmacists are prohibited from dispensing prescription drugs if they know, or should have known, that it was on the basis of an internet-based questionnaire, an internet-based consult, or a telephone consultation, all without a valid pre-existing patient-practitioner relationship.

Source: 3 CO Code of Regulation 719-1.

Workers’ Compensation

The physician-patient relationship/psychologist-patient relationship can be established through live audio/video services.


Cross State Licensing

Member of the interstate medical licensure compact.

Source: HB 1047 (2016).

Colorado adopted the interjurisdictional Compact of the Association of State and Provincial Psychology Boards (PSYPACT). (The Compact becomes effective 1/1/2020 unless a seventh state enacts the Compact before then).

Source: HB 1017 (2018).

Member of the Physical Therapy Compact.


Member of the Nurses Licensure Compact.


Miscellaneous

Colorado law includes in its definition of “health care services” the rendering of services via telemedicine.

Source: CO Revised Statutes 10-16-102.

Worker’s Compensation Telehealth/Telemedicine Definition

Telehealth - a mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, and/or self-management of an injured worker’s health care while the injured worker is located at an originating site and the provider is located at a distant site. The term includes synchronous interactions and store-and-forward transfers. The term does not include the delivery of health care services via telephone with audio only function, facsimile machine, or electronic mail systems.

Telemedicine means two-way, real time interactive communication between the injured worker, and the provider at the distant site. This electronic communication involves, at minimum, audio and video telecommunications equipment. Telemedicine enables the remote diagnoses and evaluation of injured workers in addition to the ability to detect fluctuations in their medical condition(s) at a remote site in such a way as to confirm or alter the treatment plan, including medications and/or specialized therapy.

Source: 7 CCR 1101-3, Rules 16.
### Medicaid Telehealth Reimbursement

**Summary**

Connecticut Medicaid is required to cover telemedicine services for categories of health care that the commissioner determines are appropriate, cost effective and likely to expand access. The CT Medicaid Program manuals do not mention reimbursement for telemedicine but does indicate that while they do not provide reimbursement for behavioral health services provided electronically or over the phone, there is an exception for case management behavioral health services for clients age eighteen and under. Additionally, Connecticut does provide reimbursement for electronic consults (store-and-forward) between providers under certain circumstances.

There is no reference to remote patient monitoring.

**Definitions**

**Definition for Telemedicine Demonstration Program for FQHCs:** "Telemedicine means the use of interactive audio, interactive video or interactive data communication in the delivery of medical advice, diagnosis, care or treatment...Telemedicine does not include the use of facsimile or audio-only telephone."

*Source: CT General Statute 17b-245c.*

**Live Video**

CT Medicaid is required (within available state and federal resources) to provide coverage for telehealth services for categories of health care services that the commissioner determines are clinically appropriate to be provided through telehealth, cost effective for the state and likely to expand access to services for whom accessing healthcare poses an undue hardship.

*Source: CT Public Act No. 16-198 (SB 298 – 2016).*

Connecticut’s Medical Assistance Program will not pay for information or services provided to a client by a provider electronically or over the telephone, however there is an exception for case management behavioral health services for clients age eighteen and under.

### Live Video

Case management behavioral health services for clients age eighteen and under is the only service allowed.


<table>
<thead>
<tr>
<th>Eligible Services / Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligible Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligible Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Geographic Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility/Transmission Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Remote Patient Monitoring</th>
<th>Provider Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Restrictions</th>
<th>Email / Phone / Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
</tbody>
</table>

The department shall not pay for information or services provided to a client over the telephone except for case management.


<table>
<thead>
<tr>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out of State Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>
## Definitions

"Telehealth" means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient’s physical and mental health, and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site, and (B) synchronous interactions, asynchronous store-and-forward transfers or remote patient monitoring. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail.” See private payers section.

**Source:** CT General Statute 19a, Sec. 906.

## Requirements

Each individual health insurance policy and group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall provide coverage for treatment provided via telehealth if it was covered if provided in-person and shall be subject to the same terms and conditions of the policy.

No telehealth provider can charge a facility fee.

**Source:** CT Public Act No. 15-88 (2015); SB 467.

## Parity

Coverage must be provided for telehealth if it would be covered in-person, subject to the terms and conditions of the policy.

**Source:** CT Public Act No. 15-88 (2015); SB 467.

No explicit payment parity.
### Definitions

“Telehealth” means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient’s physical and mental health, and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site, and (B) synchronous interactions, asynchronous store-and-forward transfers or remote patient monitoring. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail. See private payers section.

**Source:** CT General Statute 19a, Sec. 906.

### Consent

At the time of the initial telehealth interaction, the provider shall provide information to the patient regarding treatment information, limitations of the telehealth platform, and obtain consent from the patient to provide telehealth services and disclose to the patient’s primary care provider records of the telehealth interaction.

**Source:** CT Public Act No. 15-88 (2015); SB 467; SB 302 (2018).

### Online Prescribing

No telehealth provider shall prescribe any schedule I, II or III controlled substance through the use of telehealth, except a schedule II or III controlled substance other than an opioid drug, in a manner consistent with federal law, for the treatment of a person with a psychiatric disability or substance use disorder, including but not limited to medication assisted treatment.

**Source:** CT Public Act No. 15-88 (2015); SB 467; SB 302 (2018).

### Cross-State Licensing

Department of Public Health may establish a process of accepting an applicant’s license from another state and may issue that applicant a license to practice medicine in the state without examination, if certain conditions are met.

**Source:** CT General Statutes Sec. 20-12.

### Miscellaneous

No reference found.
**District of Columbia**

**Medicaid Program:** District of Columbia Medicaid  
**Program Administrator:** District of Columbia Dept. of Health Care Financing  
**Regional Telehealth Resource Center:** Mid-Atlantic Telehealth Resource Center  
**Covers the States of:** Delaware, Kentucky, Maryland, New Jersey, North Carolina, Pennsylvania, Virginia, and West Virginia as well as the District of Columbia  

[www.matrc.org](http://www.matrc.org)

---

### Medicaid Telehealth Reimbursement

**Summary**

Medicaid is required to pay for telehealth services (which includes live video, store-and-forward and remote patient monitoring) if the same service would be covered when delivered in-person. This law was recently amended to expand reimbursement to store-and-forward and remote patient monitoring, but doesn’t apply to Medicaid until its fiscal effect is included in an approved budget and financial plan. Consequently, D.C’s regulations and manuals have not yet been updated to reflect the changes.

*Source: DC Code Sec. 31-3863.*

### Definitions

**Recently Passed Legislation**

“Telehealth” means the delivery of health care services, including services provided via synchronous interaction and asynchronous store-and-forward, through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, remote patient monitoring, or treatment. The term “telehealth” shall not include services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions.

*Source: DC Code Sec. 31-3861.*

Telehealth is defined as the delivery of healthcare services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment, provided, that services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions are not included. For the purposes of coverage by the Department of Health Care Finance (DHCF), telehealth and telemedicine shall be deemed synonymous.

Telemedicine is a service delivery model that delivers healthcare services through a two-way, real time interactive video-audio communication for the purpose of evaluation, diagnosis, consultation, or treatment.

Recently Passed Legislation*
DC Medicaid must reimburse for health services through telehealth under certain circumstances.

**Source:** DC Code Sec. 31-3861.

Effective June 23, 2016 DC Medicaid must reimburse for health services through telehealth under certain circumstances.


Eligible Services / Specialties

Recently Passed Legislation*
DC Medicaid must reimburse for health services through telehealth if:

- The health care services are covered when delivered in-person; or
- The health care services are covered under the District’s Medicaid State Plan and any implementing regulations, including:
  - Evaluation, consultation and management;
  - Behavioral health care services;
  - Diagnostic, therapeutic, interpretive and rehabilitation services;
  - Medication adherence management services;
  - Remote patient monitoring, subject to prior authorization by the Department; and
  - Any other service as authorized by the Director of the Department through rules issued pursuant to section 4e.

Must use the reimbursement codes designated for telehealth by the Department.

**Source:** DC Code Sec. 31-3861.

Covered Services:

- Evaluation and management
- Consultation
- Behavioral healthcare services
- Speech therapy

Distant site providers may only bill for the appropriate codes outlined (see manual).

Reimbursement to a distant site for professional services shall not be shared with a referring provider at an originating site.

**Source:** DC Code Sec. 31-3861.

Must be an approved telemedicine provider. The following providers are considered an eligible originating site, as well as eligible distant site provider:

- Hospital
- Nursing facility
- Federally Qualified Health Center
- Clinic
- Physician Group/Office
- Nurse Practitioner Group/Office
- DCPS
- DCPCS
- Core Service Agency


Must be an approved telemedicine provider. The following providers are considered an eligible originating site, as well as eligible distant site provider:

- Hospital
- Nursing facility
- Federally Qualified Health Center
- Clinic
- Physician Group/Office
- Nurse Practitioner Group/Office
- DCPS
- DCPCS
- Core Service Agency

See emergency notice for special rules around reimbursement of Local Education Agencies and Core Service Agencies.


**Source:**

No reference found.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Live Video</th>
<th>Facility/Transmission Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recently Passed Legislation*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For health care services delivered through telehealth during the period between October 1, 2018, and October 1, 2019, an originating site shall receive a payment from the Department equivalent to the lesser of the reimbursement paid by the Department to a provider or the originating site facility fee of $25. Beginning October 2, 2019, the facility fee for the originating site shall be determined in accordance with the Medicare Economic Index, as determined by the United States Centers for Medicaid and Medicaid Services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source: DC Code Sec. 31-3861.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No transaction or facility fee.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy</th>
<th>Store-and-Forward</th>
<th>Eligible Services/Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recently Passed Legislation*</td>
<td></td>
<td>No reference found.</td>
</tr>
<tr>
<td>A patient receiving asynchronous store-and-forward health care services shall have the right to interact with a provider via synchronous interaction and shall be informed of this right at the time the store-and-forward services are delivered. If the provider cannot provide a synchronous interaction within 30 days of the patient’s request they won’t be reimbursed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source: DC Code Sec. 31-3861.</td>
<td></td>
<td>No reference found.</td>
</tr>
<tr>
<td>No reimbursement for store-and-forward.</td>
<td></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Geographic Limits</th>
<th>Transmission Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

| Recently Passed Legislation*      |            |                          |
| For health care services delivered through telehealth during the period between October 1, 2018, and October 1, 2019, an originating site shall receive a payment from the Department equivalent to the lesser of the reimbursement paid by the Department to a provider or the originating site facility fee of $25. Beginning October 2, 2019, the facility fee for the originating site shall be determined in accordance with the Medicare Economic Index, as determined by the United States Centers for Medicaid and Medicaid Services. |
| Source: DC Code Sec. 31-3861.     |            |                          |
## Medicaid Telehealth Reimbursement

### Recently Passed Legislation

Reimbursement for remote patient monitoring is provided as long as providers establish protocols that govern the:

- Authentication and authorization of patients;
- Process for monitoring, tracking, and responding to changes in a patient’s clinical condition;
- Acceptable and unacceptable parameters for a patient’s clinical condition;
- Response of monitoring staff to abnormal parameters of a patient’s vital signs, symptoms, or lab results;
- Process for notifying the patient’s provider of significant changes in the patient’s clinical condition;
- Prevention of unauthorized access to the provider’s information-technology systems;
- Provider’s compliance with the security and privacy requirements of the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (110 Stat. 1936; 42 U.S.C. Section 1320d et seq.);
- Storage, maintenance, and transmission of patient information;
- Synchronization and verification of patient data, as appropriate; and
- Notification of the patient’s discharge from remote patient monitoring services.

**Source:** DC Code Sec. 31-3861.

### No reimbursement for remote patient monitoring.


### Conditions

No reference found.

### Recently Passed Legislation

To receive payment for remote patient monitoring services delivered through telehealth, a provider shall:

- Assess and monitor a patient’s clinical data, including appropriate vital signs, pain levels, other biometric measures specified in the plan of care, and the patient’s response to prior changes in the plan of care;
- Assess changes, if any, in the condition of the patient observed during the course of remote patient monitoring that may indicate the need for a change in the plan of care; and
- Develop and implement a patient plan addressing:
  - Management and evaluation of the plan of care, including changes in visit frequency or addition of other health care services;
  - Coordination of care regarding telehealth findings; and
  - Coordination and referral to other providers, as needed.

The equipment used by a provider to deliver remote patient monitoring services through telehealth shall:

- Be maintained in good repair and kept free from safety hazards;
- Be newly purchased or, if previously used, sanitized before installation in the patient’s home;
- Accommodate non-English language options; and
- Provide technical and clinical support services to the patient user.

**Source:** DC Code Sec. 31-3861.
### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Remote Patient Monitoring</th>
<th>Other Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email / Phone / Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>DC Medicaid does not reimburse for service delivery using audio-only telephones, e-mail messages or facsimile transmissions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written consent required.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out of State Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>A telemedicine visit meets the definition of an encounter for a FQHC.</td>
</tr>
<tr>
<td><strong>Source:</strong> DC Municipal Regulation. Title 29, Chapter 45, Sec. 4599.</td>
</tr>
</tbody>
</table>

Special reimbursement parameters for FQHCs:

- When FQHC is originating site: An FQHC provider must deliver an FQHC-eligible service in order to be reimbursed the appropriate PPS or fee for service (FFS) rate at the originating site;
- When FQHC is distant site: An FQHC provider must deliver an FQHC-eligible service in order to be reimbursed the appropriate PPS or FFS rate; and
- When FQHC is Originating and Distant Site: In instances where the originating site is an FQHC, the distant site is an FQHC, and both sites deliver a service eligible for the same clinic visit/encounter all-inclusive PPS code, only the distant site will be eligible to be reimbursed for the appropriate PPS rate for an FQHC-eligible service. |
Telemedicine section also appears in Provider Manuals on:

- FQHCs
- Clinics
- Inpatient Hospital
- Outpatient Hospital

As a condition of participation, Medicaid providers using telemedicine will be required to respond to requests for information on their telemedicine program.


DHCF is required to send a Telemedicine Program Evaluation survey to providers, effective Jan. 1, 2017.

*Source: DC Municipal Regulation. Title 29, Ch. 9, Sec. 910. 99.*

**Definitions**

“Telehealth” means the delivery of healthcare services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment; provided, that services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions are not included.

*Source: DC Code Sec. 31-3861.*

**Requirements**

Private payers are required to pay for telehealth services if the same service would be covered when delivered in-person.

A health insurer may not impose any annual or lifetime dollar maximum on coverage for telehealth services.

*Source: DC Code Sec. 31-3862.*

**Parity**

A health plan must reimburse a provider for the diagnosis, consultation or treatment of the patient when the service is delivered by telehealth.

**Payment Parity**

No explicit payment parity.
<table>
<thead>
<tr>
<th>Professional Regulation/Health &amp; Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions</td>
</tr>
<tr>
<td><strong>Telemedicine</strong> - The practice of medicine by a licensed practitioner to provide patient care, treatment or services, between a licensee in one location and a patient in another location with or without an intervening healthcare provider, through the use of health information and technology communications, subject to the existing standards of care and conduct.</td>
</tr>
<tr>
<td>Source: DC Regs. Sec. 17-4699.</td>
</tr>
<tr>
<td>Consent</td>
</tr>
<tr>
<td>Must obtain and document consent.</td>
</tr>
<tr>
<td>Source: DC Code Sec. 17-4618.</td>
</tr>
<tr>
<td>Online Prescribing</td>
</tr>
<tr>
<td>A physician-patient relationship can be established through real-time telemedicine.</td>
</tr>
<tr>
<td>Source: DC Code Sec. 17-4618.</td>
</tr>
<tr>
<td>Cross-State Licensing</td>
</tr>
<tr>
<td><strong>Recently Passed Legislation</strong></td>
</tr>
<tr>
<td>DC enacted the Interstate Medical Licensure Compact.</td>
</tr>
<tr>
<td>Must have license to practice medicine in the District of Columbia.</td>
</tr>
<tr>
<td>Source: DC Code Sec. 17-4618.</td>
</tr>
<tr>
<td>Miscellaneous</td>
</tr>
<tr>
<td><strong>Professional Board Telehealth-Specific Regulations</strong></td>
</tr>
<tr>
<td>• Department of Health (applies to the Board of Medicine)</td>
</tr>
<tr>
<td>Source: DCMR Title 17, Ch. 46 Sec. 4618.</td>
</tr>
</tbody>
</table>

* Applies upon the date of inclusion of its fiscal effect in an approved budget and financial plan.
**Medicaid Program:** Delaware Medical Assistance Program (DMAP)

**Program Administrator:** Delaware Health and Social Services Dept., Division of Social Services

**Regional Telehealth Resource Center:** Mid-Atlantic Telehealth Resource Center

**Covers the States of:** Delaware, Kentucky, Maryland, New Jersey, North Carolina, Pennsylvania, Virginia, and West Virginia as well as the District of Columbia

www.matrc.org

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary</strong></td>
</tr>
<tr>
<td>Delaware Medical Assistance Program (DMAP) reimburses for live video telemedicine for certain providers and for patients at specific sites. DMAP does not reimburse for store-and-forward and makes no reference to remote patient monitoring.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Telemedicine” is a cost-effective alternate to face-to-face encounters where access to care is compromised due to the lack of available service providers in the patient’s geographical location. This definition is modeled on Medicare’s definition for telehealth services located at 42 CFR Sec. 410.78. Note that the Federal Medicaid statute does not recognize telemedicine as a distinct service. For purposes of DMAP, telemedicine is the use of medical or behavioral health information exchanged from one site to another site via an electronic interactive (two-way, real time) telecommunications system to improve a patient’s health.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Live Video</th>
</tr>
</thead>
<tbody>
<tr>
<td>DE Medicaid reimburses for live video telemedicine services for up to three different consulting providers for separately identifiable telemedicine services provided to a member per date of service.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>The GT modifier (which indicates the service occurred via interactive audio and video telecommunication system) can be used for Early and Periodic Screening, Diagnostic and Treatment Services through the School Based Health Services program.</td>
</tr>
</tbody>
</table>

The GT modifier (which indicates the service occurred via interactive audio and video telecommunication system) can be used for Early and Periodic Screening, Diagnostic and Treatment Services through the School Based Health Services program.


Eligible disorders include:

- Inpatient/outpatient hospitals
- Physicians (or PAs under the physician’s supervision)
- Certified Nurse Practitioners
- Nurse Midwives
- Licensed Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Counselors of Mental Health
- Speech Language Therapists
- Audiologists
- Other providers as approved by the DMAP


An originating site can include the member’s place of residence, day program or alternative location in which the member is physically present and telemedicine can be effectively utilized.


Medical Professional Sites:

- Physicians (or PAs under the supervision of a physician)
- Certified Nurse Practitioner
- Medical and Behavioral Health Therapists


An approved originating site may include the DMAP member’s place of residence.

Source: 19 DE Reg. 191.

No reference found.
Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Live Video</th>
<th>Facility/Transmission Fee</th>
</tr>
</thead>
</table>

A facility fee for the following originating site providers is covered:

- Outpatient hospitals
- Inpatient Hospitals
- FQHCs
- RHCs
- Renal Dialysis Centers
- Skilled Nursing Facilities
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Intermediate Care Facilities/Institutions for Mental Diseases (ICF/IMDs)
- Outpatient Mental Health/Substance Abuse Centers/Clinics
- Community Mental Health Centers/Clinics
- Public Health Clinics
- PACE Centers
- Assisted Living Facilities
- School-based Wellness Centers
- Other sites approved by DMAP

Patient’s home qualifies as originating site, but does not warrant an originating site fee.

Facility fees for the distant site are not covered.


<table>
<thead>
<tr>
<th>Store-and-forward</th>
<th>Eligible Services/Specialties</th>
</tr>
</thead>
</table>

Asynchronous or “store-and-forward” applications do not meet the DMAP definition of telemedicine.


<table>
<thead>
<tr>
<th>Geographic Limits</th>
<th>No reference found.</th>
</tr>
</thead>
</table>

No reference found.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Store-and-Forward Transmission Fee</th>
<th>No reference found.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote Patient Monitoring</td>
<td>Policy</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Conditions</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Provider Limitations</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Other Restrictions</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Email / Phone / Fax</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone, chart review, electronic mail messages, facsimile transmissions or internet services for online medical evaluations are not considered telemedicine.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Federally Qualified Health Centers** |
| Telephone consultations are covered services that are included in the payment made to the FQHC and should not be billed as an encounter. |

| **Consent** |
| Recipient must provide consent to use telemedicine. It must be obtained by either the referring, consulting, or distant provider. An exception is made for involuntary detention and commitment. |

| **Out of State Providers** |
| The Distant site provider must be located within the continental US. |

| **Miscellaneous** |
| Provider manual lays out three different models for prescribing: |
| **First Model:** Distant site provider consults with referring provider about appropriate medication. Referring provider executes prescription. |
| **Second Model:** Consulting provider works with medical professional at the originating site to provide front line care, including prescription writing. |
| **Third Model:** The consulting provider prescribes and sends/calls-in the initial prescription. |

For stimulants, narcotics and refills, hard copy prescriptions can be written and sent via delivery service to the referring site for the consumer to pick up a couple days after the appointment (see manual for more details). |


Confidentiality, privacy and electronic security standards for telemedicine as well as a contingency plan required of telemedicine sites is listed in the DE Behavioral Health Service Certification and Reimbursement manual. |

Group and Blanket Insurance, & Health Insurance Contracts
Also applies to: Physicians, Podiatry, Optometry, Chiropractic, Dentistry, Nursing, Occupational Therapy, Physical Therapy, Mental Health, Psychology, Dietetic and Nutrition Therapy, Pharmacy, and Clinical Social Work

Telehealth means the use of information and communications technologies consisting of telephone, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.

Source: Title 18, Sec. 3370; & Title 18, Sec. 3571R; DE Code Title 24, Sec. 1702, Sec. 502, Sec. 701, Sec. 1101, Sec. 1902, Sec. 2002, Sec. 2101, Sec. 2502, Sec. 3002, Sec. 3502, Sec. 3802, Sec. 2500, & Sec. 3902.

Group and Blanket Insurance, & Health Insurance Contracts

Telemedicine means a form of telehealth which is the delivery of clinical health care services by means of real-time two-way audio, visual or other telecommunications or electronic communications, including the application of secure video conferencing or store-and-forward transfer technology to provide or support healthcare delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site.

Source: Title 18, Sec. 3370; & Title 18, Sec. 3571R.

Private Payer Laws

Requirements

Private payers must provide coverage for the cost of health care services provided through telemedicine, and telehealth as directed through regulations by the Department. Insurers must pay for telemedicine services at the same rate as in-person. Payment for telemedicine must include reasonable compensation to the originating or distant site for the transmission cost.

Source: Title 18, Sec. 3370; & Title 18, Sec. 3571R.

Parity

Service Parity

A payer must reimburse the provider for the diagnosis, consultation, or treatment of the patient on the same basis as in-person services for telemedicine.

Source: Title 18, Sec. 3370; & Title 18, Sec. 3571R.

Payment Parity

Insurers must pay for telemedicine services at the same rate as in-person.

Source: Title 18, Sec. 3370; & Title 18, Sec. 3571R.
Applies to: Physical Therapy, dietetics and nutrition services  “Telehealth, as set forth in the Board’s rules and regulations, means the use of electronic communications to provide and deliver a host of health-related information and healthcare services, including physical therapy and athletic training related information and services, over large and small distances. Telehealth encompasses a variety of healthcare and health promotion activities, including education, advice, reminders, interventions, and monitoring of intervention.”

Source: DE Code. Title 24, Sec. 2602.

Applies to: Occupational Therapy  “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.


Applies to: Physicians, Podiatry, Optometry, Chiropractic, Dentistry, Nursing, Occupational Therapy, Mental Health, Psychology, Dietetic and Nutrition Therapy, Clinical Social Work  Telemedicine means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual or other telecommunications or electronic communications, including the application of secure video conferencing or store-and-forward transfer technology to provide or support healthcare delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation.

Source: DE Code Title 24, Sec. 1702, Sec. 502, Sec. 701, Sec. 1101, Sec. 1902, Sec. 2002, Sec. 2101, Sec. 2502, Sec. 3002, Sec. 3502, Sec. 3802, & Sec. 3902.

Applies to: Mental Health Counseling, Chemical Dependency Counseling, or Marriage and Family Therapy  “Telehealth Services” means the practice of Mental Health Counseling, Chemical Dependency Counseling, or Marriage and Family Therapy (hereinafter referred to as Behavioral Health Practice) by distance communication technology such as but not necessarily limited to telephone, email, Internet-based communications, and videoconferencing.

Source: DE Admin. Code Tittle 24, Sec. 3000.

NOTE: DE Professional Boards each have a different definition of telehealth/telepractice/telemedicine. See “Comments” section for references.

Informed consent must be obtained to establish a physician-patient relationship over telehealth.

Source: Title 24, Sec. 1769D & DE Code Title 24, Sec. 1933.

Applies to: Mental Health Counseling, Chemical Dependency Counseling, or Marriage and Family Therapy  Informed consent required by Boards (see regulation citations in “Comment” area).
Pharmacists are prohibited from dispensing prescription drug orders through an Internet pharmacy if the pharmacist knows that the prescription order was issued solely on the basis of an Internet consultation or questionnaire, or medical history form submitted to an Internet pharmacy through an Internet site.

**Source:** DE Code, Title 16 Sec. 4744.

**APRNs and Physicians**

Establishing a proper provider-patient relationship includes:

- Verifying the location of requesting patient;
- Disclosing the provider’s identity and credentials;
- Obtaining consent;
- Establishing a diagnosis through acceptable medical practices, including a physical exam;
- Discuss with patient the diagnosis;
- Ensure availability of distant site provider or coverage of patient for follow up care; and
- Provide written visit summary to patient.

**Physician & APRNs**

Without a prior patient-provider relationship providers are prohibited from issuing prescriptions based on internet questionnaire, internet consult or a telephone consult.

Prescriptions through telemedicine and under a physician-patient relationship may include controlled substances, subject to limitations set by the Board.

**Source:** Title 24, Sec. 1769D & DE Code Title 24, Sec. 1933.

**Physicians**

Prior to a diagnosis and treatment a physician using telemedicine must either provide:

- An appropriate in-person exam;
- Have another DE licensed practitioner at the originating site with the patient at the time of diagnosis;
- Diagnosis must be based using both audio and visual communication; or
- The service meets standards of establishing a patient-physician relationship included as part of evidenced-based clinical practice guidelines in telemedicine developed by major medical specialty societies.

After a relationship has been established, subsequent treatment of the same patient with the same physician need not satisfy the limitations of this section.

This section shall not limit the practice of radiology or pathology.

**Source:** Title 24, Sec. 1769D.

A remote audio only examination is not an “appropriate in-person examination”.

No opioid prescribing is permitted via telemedicine with the exception of addiction treatment programs offering medication assisted treatment that have received a Division of Substance Abuse and Mental Health (DSAMH) waiver to use telemedicine through DSAMH’s licensure or renewal process. All other controlled substance prescribing utilizing telemedicine is held to the same standards of care and requisite practice as prescribing for in-person visits.

For formation of the physician-patient relationship using audio and visual communications, the audio and visual communications must be live, real-time communications.

**Source:** DE Admin Code. Sec. 1700. Sec. 19.
Member of Nurses Licensure compact.


Professional regulation with telehealth specific standards

- Physical Therapists and Athletic Trainers (Source: DE Statute Title 24, Sec. 2602)
- Board of Mental Health and Chemical Dependency Professionals (Source: 24 DAC 3000)
- Board of Clinical Social Work Examiners (Source: 24 DAC 3900)
- Respiratory Care Practice Advisory Council (Source: 24 DAC 1769D)
- Board of Examiners in Optometry (Source: 24 DAC 2100)
- Board of Occupational Therapy Practice (Source: 24 DAC 2000)
- Board of Speech/Language Pathologists, Audiologists and Hearing Aid Dispensers (Source: 24 DAC 3700)
- Board of Dietetics/Nutrition (Source: 24 DAC 3800)
- Board of Dentistry and Dental Hygiene (Source: 24 DAC 1100)
- Genetic Counselor Advisory Council (Source: 24 DAC 1799)
- Pharmacy (Source: 24 DAC 2500)
Florida

Medicaid Program: Florida Medicaid
Program Administrator: Florida Dept. of Children and Families
Regional Telehealth Resource Center: Southeast Telehealth Resource Center
Covers the States of: Alabama, Florida, Georgia & South Carolina
www.setrc.us

FL Medicaid reimburses for real time interactive telemedicine according to administrative code, but Medicaid Manuals only indicate reimbursement in Community Behavioral Health Services. No reference was found in regards to reimbursement for store-and-forward or remote patient monitoring.

Telemedicine is "the use of telecommunication and information technology to provide clinical care to individuals at a distance, and to transmit the information needed to provide that care."


Some telemedicine services reimbursed in the Community Behavioral Health Services, per the Fee Schedule.


FL Medicaid reimburses for real time interactive telemedicine.


Some telemedicine services reimbursed in the Community Behavioral Health Services, per the Fee Schedule.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Eligible Providers</th>
<th>Eligible Sites</th>
<th>Geographic Limits</th>
<th>Facility/Transmission Fee</th>
<th>Policy</th>
<th>Eligible Services/Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLORIDA / 02</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td>Live Video</td>
<td>Geographic Limits</td>
<td>Transmission Fee</td>
<td>Policy</td>
<td>Conditions</td>
<td>Provider Limitations</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------</td>
<td>-------------------</td>
<td>------------------</td>
<td>-------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
Medicaid Telehealth Reimbursement

No reimbursement for telephone, chart review, electronic mail messages or facsimile transmissions.


Email / Phone / Fax

No reference found.

Consent

No reference found.

Out of State Providers

No reference found.

Miscellaneous

Florida created a Telehealth Advisory Council for purpose of making recommendations to the Governor and the Legislature about telehealth.

The state’s Agency for Health Care Administration, the Department of Health (DOH) and the Office of the Insurance Regulation was also required to survey FL providers on their utilization of telehealth.


In 1998, the Child Protection Team (CPT) Program implemented a telemedicine network that links CPT teams with remote or satellite CPT offices, or local facilities, such as hospital emergency rooms, county health departments, or child advocacy centers, to facilitate telemedicine assessments for abuse, abandonment, and neglect of children in remote or rural areas.

Only specially trained CPT physicians, advanced registered nurse practitioners or physician assistants can perform these exams. And only specifically trained registered nurses at presenting sites may participate in the exam.


Florida Children’s Medical Services (CMS) is a collection of programs for special needs children. CMS’ Telemedicine Program services are provided by approved CMS Network providers to Medicaid children enrolled in CMS. Eligible sites are limited.

<table>
<thead>
<tr>
<th>Professional Regulation/Health &amp; Safety</th>
<th>Definitions</th>
</tr>
</thead>
</table>
|                                        | "Telemedicine means the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, and facsimile transmission. Source: FL Admin Code 64B8-9.0141 & 64B15-14.0081."
| Consent                                | No reference found. |

<table>
<thead>
<tr>
<th>Private Payer Laws</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>
Controlled substances shall not be prescribed through the use of telemedicine, except for the treatment of psychiatric disorders.

Exception: physicians can order controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to Ch. 395, F.S.

Prescribing medication solely on the basis of an electronic medical questionnaire is not allowed.

A physician-patient relationship may be established through telemedicine.


Prior to e-prescribing, physicians and physician assistants must document a patient evaluation, including history and physical examination, to establish the diagnosis for which any drug is prescribed, and discuss treatment options with the patient.

These rules don’t apply in emergency situations.


Member of the Nurses Licensure Compact.


At the time of license renewal all practitioners must fill out a Telehealth Practitioner Survey.

Source: FL Admin Code 64B8-9.008.

Professional Board Telehealth-Specific Regulations

- FL Board of Medicine (Source: FL Admin Code 64B8-9.0141).
Georgia

**Medicaid Program:** Georgia Medicaid  
**Program Administrator:** Georgia Dept. of Community Health  
**Regional Telehealth Resource Center:** Southeast Telehealth Resource Center  
**Covers the States of:** Alabama, Florida, Georgia & South Carolina  
www.setrc.us

### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgia Medicaid reimburses for live video under some circumstances. Store-and-forward is not reimbursable as interactive telecommunications is a condition of payment, however GA Medicaid will reimburse for the technical component of x-rays, ultrasounds, etc. as well as store-and-forward teledentistry. There is no reference to remote patient monitoring.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
</table>
| Telemedicine is the use of medical information exchange from one site to another via electronic communications to improve patient’s health status. It is the use of two-way, real time interactive communication equipment to exchange the patient information from one site to another via an electronic communication system. This includes audio and video communications equipment.  
Closely associated with telemedicine is the term “telehealth,” which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Telehealth is the use of telecommunications technologies for clinical care (telemedicine), patient teachings and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system. |


<table>
<thead>
<tr>
<th>Live Video</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgia Medicaid reimbursement for telehealth is specific to clinical services rendered via telemedicine. See each program manual for associated telemedicine guidelines.</td>
</tr>
</tbody>
</table>
The service must be medically necessary and the procedure individualized, specific, and consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the member’s needs.

Eligible services:

- Office visits;
- Pharmacologic management;
- Limited office psychiatric services;
- Limited prevention intervention services;
- Limited radiological services;
- A limited number of other physician fee schedule services.

See telemedicine manual for list of eligible telemedicine codes.

Non-Covered Services:

1. Telephone conversations.
2. Electronic mail messages.
3. Facsimile.
4. Services rendered via a webcam or internet based technologies (i.e., Skype, Tango, etc.) that are not part of a secured network and do not meet HIPAA encryption compliance.
5. Video cell phone interactions.
6. The cost of telemedicine equipment and transmission.
7. Store-and-forward transactions
8. Failed or unsuccessful transmissions.


Georgia Medicaid will reimburse for mental health services for residents in nursing homes via telemedicine (although not available in all areas of the state) for “dual eligibles” (Medicaid and Medicare).

Nursing facilities and community behavioral health rehabilitation (CBHRS) service providers can arrange for the provision of specialized services to residents either in nursing facilities, via telemedicine or at the CBHRS location for residents in the Preadmission Screening and Resident Review Serious Mental Illness and dually diagnosed populations.


Eligible distant practitioners:

- Physicians
- Nurse practitioner
- Physician assistant
- Nurse-midwives
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Dentists and dental hygienists
- Community mental health centers;
- Community behavioral health providers;
- Community mental health centers;
- Clinical psychologists (CPs) and clinical social workers (CSWs);
- Speech language pathologists;
- Registered dietitians or nutrition professionals.

### Medicaid Telehealth Reimbursement

#### Eligible Providers

FQHCs and RHCs are authorized to serve as a distant site for telehealth services, and may bill the cost of the visit.


#### Eligible Sites

Eligible originating sites:

- Provider offices;
- Hospitals;
- Rural Health Clinics (RHC);
- Federally Qualified Health Centers (FQHC);
- Hospital based or CAH based renal Dialysis Centers;
- Skilled nursing facilities;
- Local Education Authorities and School Based Clinics;
- County Boards of Health;
- Emergency Medical Services Ambulances; and
- Pharmacies


Local Education Agencies are allowed to enroll in the Health Check Program to serve as telemedicine originating sites only.


#### Geographic Limits

No reference found.

#### Facility/Transmission Fee

Rural Health Clinics, FQHCs and LEAs enrolled as Health Check providers can collect a telehealth originating site facility fee.


FQHCs and RHCs cannot bill an originating site fee and distant site fee for telehealth services on the same encounter.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Store-and-Forward</th>
<th>Eligible Services/Specialties</th>
<th>Geographic Limits</th>
<th>Transmission Fee</th>
<th>Policy</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>Reimbursement can be made for technical component of store-and-forward applications such as an MRI, X-rays or ultrasounds. However, no other reimbursement can be made.</td>
<td>Source: GA Dept. of Community Health, GA Medicaid Telemedicine Guidance Handbook, p. 6, (Jul. 2018). (Accessed Sep. 2018).</td>
<td>No reference found.</td>
<td>The originating site fee (billed as D9996) associated with a real time teledentistry exam is supposed to cover the asynchronous sending of information by a dental hygienist to a dentist for review.</td>
<td>Source: GA Dept. of Community Health, GA Medicaid Dental Services Handbook. (Jul. 2018). (Accessed Sep. 2018).</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Georgia Medicaid will not reimburse for store-and-forward because an interactive tele-communication system is a condition of payment. The exception is that Georgia Medicaid allows for reimbursement of teledentistry.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia Medicaid allows for reimbursement of store-and-forward teledentistry.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© 2018 Public Health Institute / Center for Connected Health Policy
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote Patient Monitoring</td>
</tr>
<tr>
<td>Provider Limitations</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Other Restrictions</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Email / Phone / Fax</td>
</tr>
<tr>
<td>No reimbursement for FAX.</td>
</tr>
<tr>
<td>No reimbursement for telephone.</td>
</tr>
<tr>
<td>No reimbursement for email.</td>
</tr>
<tr>
<td>Consent</td>
</tr>
<tr>
<td>The referring provider must obtain prior written consent.</td>
</tr>
<tr>
<td>Out of State Providers</td>
</tr>
<tr>
<td>Providers must have a Georgia license.</td>
</tr>
<tr>
<td>Miscellaneous</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>
### Private Payer Laws

#### Definitions

"Telemedicine means the practice, by a duly licensed physician or other health care provider acting within the scope of such provider’s practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient. Standard telephone, facsimile transmissions, unsecured e-mail, or a combination thereof do not constitute telemedicine services."

**Source:** Official Code of GA Annotated Sec. 33-24-56.4 (2012).

#### Requirements

Requires payment of telemedicine for services that are covered under the plan, subject to contract terms and conditions.

**Source:** Official Code of GA Annotated Sec. 33-24-56.4 (2012).

#### Parity

Services must be appropriately provided through telemedicine and in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. It is also subject to all the terms and conditions of the applicable health benefit plan.

**Source:** Official Code of GA Annotated Sec. 33-24-56.4 (2012).

#### Payment Parity

No explicit payment parity.

### Professional Regulation/Health & Safety

#### Definitions

**Applies to:** Interactive Physical Therapy Services

“Telehealth” is the use of electronic communications to provide and deliver a host of health related information and health care services including, but not limited to physical therapy related information and services, over large and small distances. Telehealth encompasses a variety of health care and health promotion activities including, but not limited to, education, advice, reminders, interventions, and monitoring of interventions.

**Source:** GA Rules & Regulations. Sec. 490-9-.06.

#### Consent

No reference found.
<table>
<thead>
<tr>
<th>Professional Regulation/Health &amp; Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Online Prescribing</strong></td>
</tr>
<tr>
<td>Physicians are prohibited from prescribing controlled substances or dangerous drugs based solely on an electronic consult.</td>
</tr>
<tr>
<td><strong>Source:</strong> GA Rules &amp; Regulations revised 360-3-.02 (2012).</td>
</tr>
</tbody>
</table>

| Cross-State Licensing                   |
| Must be a Georgia licensed practitioner. |
| **Source:** GA Admin. Code Sec. 360-3-.07. |
| Member of Nurse Licensure Compact.      |

| Miscellaneous                           |
| Professional Board Telehealth-Specific Regulations |
| • GA Composite Medical Board (**Source:** GA Admin. Code Sec. 360-3-.07). |
| • GA Board of Physical Therapy (**Source:** GA Admin. Code Sec. 490-9-.06). |
**Hawaii**

**Medicaid Program:** Hawaii Medicaid  
**Program Administrator:** Hawaii Dept. of Human Services  
**Regional Telehealth Resource Center:** Pacific Basin Telehealth Resource Center  
**Covers the States of:** Hawaii & US affiliated Pacific Islands  
[www.pbtrc.org](http://www.pbtrc.org)

---

### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hawaii Medicaid reimburses for live video. Although their statute prohibits HI Medicaid from placing any restrictions on originating sites, regulations creating restrictions on the types of originating site eligible for reimbursement and their geographic location still exist in Hawaii Rules. HI indicated in a memo that a state plan amendment was approved that allows for the changes in Hawaii Medicaid policy based on the statutory requirements, but it did not provide any specifics on removing the originating site or geographic restrictions currently present in HI rules. Additionally, according to Hawaii’s statutory definition of telehealth, they should also be reimbursing for store-and-forward and remote patient monitoring, however CCHP has yet to find any documentation from Hawaii Medicaid that they are reimbursing for these modalities.</td>
</tr>
</tbody>
</table>

### Definitions

“Telehealth” means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store-and-forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this section.”

**Source:** HI Revised Statutes Ch. 346, § 346-59.1(g).

### Live Video

**Policy**

Hawaii Medicaid is required under statute to reimburse telehealth equivalent to reimbursement for the same services provided via face-to-face contact.

**Source:** HI Revised Statutes § 346-59.1(b).

Hawaii Quest will reimburse for live video, as long as it “includes audio and video equipment, permitting real-time consultation among the patient, consulting practitioner and referring practitioner.”

**Source:** Code of HI Rules 17-1737-15.1(c).
**Eligible Services / Specialties**

GT, GQ or 95 modifier must be use. See Attachment A in Med-QUEST Memo for full list of CPT codes that are “prime candidates” for telehealth services. Distant site providers should use the 02 Place of Service Code. Codes listed in Attachment A are considered prime candidates for telehealth reimbursement.


---

<table>
<thead>
<tr>
<th>Eligible Sites</th>
</tr>
</thead>
</table>

Eligible originating sites:

- The office of a physician or practitioner;
- Hospitals;
- Critical Access Hospitals;
- Rural Health Clinics;
- Federally Qualified Health Centers;
- Federal telehealth demonstration project sites.

*Source: Code of HI Rules 17-1737. – Law passed & state plan amendment accepted prohibiting this limitation, however the prohibiting language is still present in regulation.*

Approved state plan amendment authorizes HI Medicaid to remove geographic and originating site requirements.


---

| Geographic Limits |

In addition, originating sites must be located in one of the following:

- A federally designated Rural Health Professional Shortage Area;
- A county outside of a Metropolitan Statistical Area;
- An entity that participates in a federal telemedicine demonstration project.

*Source: Code of HI Rules 17-1737. – Law passed & state plan amendment accepted prohibiting this limitation, however the prohibiting language is still present in regulation.*

Approved state plan amendment authorizes HI Medicaid to remove geographic and originating site requirements.

### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Service</th>
<th>Policy</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Live Video</strong></td>
<td>Hawaii Medicaid and private payers are required to cover appropriate telehealth services (which includes store-and-forward) equivalent to reimbursement for the same services provided in-person.</td>
<td><em>Source: HI Revised Statutes § 346 &amp; 431:10A-116.3 (SB 2395 - 2018).</em></td>
</tr>
<tr>
<td><strong>Facility/Transmission Fee</strong></td>
<td>Hawaii Quest requires under the definition of originating site that the patient to be “present and participating in the telehealth visit” when the telehealth service is being provided therefore excluding store-and-forward from reimbursement.</td>
<td><em>Source: HI Revised Statutes Ch. 346, § 59.1.</em></td>
</tr>
</tbody>
</table>

**Federally Qualified Health Centers**
Telemedicine-based retinal imaging and interpretation is not a covered service for PPS reimbursement. A face-to-face encounter with a member by an ophthalmologist or optometrist is eligible for PPS reimbursement, regardless of whether retinal imaging or interpretation is a component of the services provided.


<table>
<thead>
<tr>
<th><strong>Store-and-forward</strong></th>
<th><strong>Policy</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Remote Patient Monitoring</strong></td>
<td>Hawaii Medicaid and private payers are required to cover appropriate telehealth services (which includes store-and-forward and remote patient monitoring) equivalent to reimbursement for the same services provided in-person.</td>
<td><em>Source: HI Revised Statutes Ch. 346, § 59.1.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Geographic Limits</strong></th>
<th>No reference found.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transmission Fee</strong></td>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td><strong>Eligible Services/Specialties</strong></td>
<td>Hawaii Medicaid and private payers are required to cover appropriate telehealth services (which includes store-and-forward and remote patient monitoring) equivalent to reimbursement for the same services provided in-person.</td>
<td><em>Source: HI Revised Statutes Ch. 346, § 59.1.</em></td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remote Patient Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Limitations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Restrictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email / Phone / Fax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of State Providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hawaii</strong></td>
<td><strong>Alaska</strong></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td><strong>Hawaii and Alaska are the only two states with Medicare coverage of store-and-forward services.</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **Definitions** | “Telehealth” means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store-and-forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this section.”

*Source: HI Revised Statutes § 431:10A-116.3(g).*

**Applies to network adequacy:** Telehealth means health care services provided through telecommunications technology by a health care professional who is at a location other than where the covered person is located.

*Source: HI Revised Statutes Ch. 431.*

<table>
<thead>
<tr>
<th><strong>Private Payer Laws</strong></th>
<th><strong>Requirements</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insurance plans</strong></td>
<td>Insurance plans cannot require face-to-face contact between a health provider and a patient as a prerequisite for payment for services appropriately provided through telehealth.</td>
</tr>
<tr>
<td><strong>All insurers</strong></td>
<td>All insurers must provide to current and prospective insureds a written disclosure of covered benefits associated with telehealth services.</td>
</tr>
</tbody>
</table>

*Source: HI Revised Statutes § 431:10A-116.3.*

<table>
<thead>
<tr>
<th><strong>Parity</strong></th>
<th><strong>Service Parity</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage</strong></td>
<td>Coverage may be subject to all the terms and conditions of the plan agreed upon among the enrollee or subscriber, the insurer and the health care provider.</td>
</tr>
</tbody>
</table>

*Source: HI Revised Statutes § 431:10A-116.3(b).*

| **Payment Parity** | Reimbursement for services provided through telehealth must be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and patient. |

*Source: HI Revised Statutes § 431:10A-116.3(c).*
### Definitions

“Telehealth” means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store-and-forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this section.”

*Source: HI Revised Statutes Ch. 453-1.3.*

### Consent

No reference found.

### Online Prescribing

Prescribing providers must have a provider-patient relationship prior to prescribing. This includes:

- A face-to-face history and appropriate physical exam to make a diagnosis and therapeutic plan;
- Discussion of diagnosis or treatment with the patient;
- Ensure the availability of appropriate follow-up care.

*Source: HI Revised Statutes § 329-1.*

Treatment recommendations made via telemedicine are appropriate for traditional physician-patient settings that do not include a face-to-face visit, but in which prescribing is appropriate, including on-call telephone encounters and encounters for which a follow-up visit is arranged.

Issuing a prescription based solely on an online questionnaire is prohibited.

A physician-patient relationship may be established via telehealth if the patient is referred to the telehealth provider by another health care provider who has conducted an in-person consultation and has provided all pertinent patient information to the telehealth provider.

*Source: HI Revised Statutes § 453-1.3.*

For purposes of prescribing medical cannabis, a bona fide physician-patient relationship may be established via telehealth, and a nurse-patient relationship can be established via telehealth; provided that treatment recommendations that certify a patient for the medical use of cannabis via telehealth shall be allowed only after an initial in-person consultation between the certifying physician or advanced practice registered nurse and the patient.

*Source: HI Revised Statutes § 329-126 (HB 2729 - 2018).*
A licensed out-of-state practitioner of medicine or surgery can utilize telemedicine to consult with a Hawaii licensed physician or osteopathic physician as long as they don’t open an office or meet with patients in the state; the HI licensed provider retains control of the patient; and the laws and rules relating to contagious diseases are not violated.

Commissioned medical officers or psychologists employed by the US Department of Defense and credentialed by Tripler Army Medical Center are exempt from licensing requirements when providing services to neighbor island beneficiaries within a Hawaii national guard armory.

Source: HI Revised Statutes Sec. 453-2(3-4).

Licensed out-of-state radiologists who are located in Hawaii, may provide services via telemedicine to patients located in the radiologist’s home state.

Source: HI Revised Statutes § 453-2(b) (7).

Professional liability insurance for health care providers must provide malpractice coverage for telehealth equivalent to coverage for the same services provided via face-to-face contact.

Source: HI Revised Statutes §671-7(a).
Idaho Medicaid reimburses for live video telehealth for certain providers and for specific services. There is no reference to store-and-forward or remote patient monitoring.

**Definitions**

**Telehealth:** Health care services delivered by a provider to a participant through the use of electronic communications, information technology, synchronous interaction between a provider at a distant site and a patient at an originating site.


**Children’s Waiver Services:** “Telehealth is an electronic real-time synchronized audio-visual contact between a consultant and participant related to the treatment of the participant. The consultant and participant interact as if they were having a face-to-face service.”

*Source:* ID Administrative Code 16.03.10.681(07).

**Live Video Policy**

Idaho Medicaid reimburses for specific services via live video telehealth, consistent with ID Administrative Code.


Rendering providers must provide timely coordination of services, within three business days, with the participant’s primary care provider who should be provided in written or electronic format a summary of the visit, prescriptions and DME ordered.


Telehealth services that are properly identified in accordance with billing requirements are covered under Medicaid for physicians, within limitations defined by the Department in the Idaho Medicaid Provider Handbook. Subject to primary care provider communication requirements.

Telehealth services are covered for advanced practice registered nurses enrolled as Healthy Connections providers, within the limitations defined in the Idaho Medicaid Provider Handbook.

*Source:* ID Administrative Code 16.03.09 Sec. 210, 502 & 565.
Services must be equal in quality to services provided in-person.


Allowable codes are listed as part of the Medicaid Fee Schedule. Additionally, five codes were added on July 1, 2018 for psychiatric crisis and early intervention service codes.

Claims must include a HCPCS modifier GT. FQHC, RHC or IHS providers must include the GT modifier with the CPT Code with their encounter.


Physician/Non-Physician Practitioner Services:

• Primary Care Services
• Specialty Services
• Psychotherapy with evaluation and management
• Psychiatric diagnostic interview
• Pharmacological management
• Tobacco Use Cessation

Physician or Psychiatric Nurse Practitioner only services:

• Psychiatric crisis services

Behavioral health services can be delivered via telehealth under a managed care contract.

Community Based Rehabilitation Services (CBRS)
CBRS supervision can be delivered via telehealth in educational environments, but not separately reimbursable.

Developmental Disabilities
Therapeutic consultation and crisis intervention can be delivered via telehealth technology through the Bureau of Developmental Disability Services.

Early Intervention Services (EIS) for Infants and Toddlers
Services can be delivered via telehealth as long as the provider is employed by or contracted with the Idaho Infant Toddler Program and meet the IDEA Part C requirements.

Primary Care
Primary care services can be delivered via telehealth. Providers must be licensed by the Idaho Board of Medicine.

Therapy Services
Licensed occupational and physical therapists and speech language pathologists can provide services through telehealth. Evaluations must be performed as an in-person visit to the participant and is not covered through telehealth.

The therapist must certify that the services can be safely and effectively done with telehealth. The physician order must specifically allow the services to be provided via telehealth.

Interpretation Services and Technical Specifications
Idaho Medicaid reimburses for oral and sign language interpretive services in conjunction with a reimbursable Medicaid service.

**Children’s Waiver Services**
Telehealth resources may be used to provide consultation during a crisis intervention.

*Source: ID Administrative Code 16.03.10.683 (06f).*

Community Based Rehabilitation Services (CBRS) supervision is included in the CBRS reimbursement rate. It is not separately reimbursable.


**Eligible Providers:**
- Physician or non-physician practitioner
- Psychiatric Nurse Practitioner
- Physical Therapist
- Occupational Therapist
- Speech language pathologists

Only one eligible provider may be reimbursed for the same service per participant per date of service.

**Healthy Connections Eligible Providers (if enrolled as primary care providers):**
- Advanced practice registered nurse
- Physician assistants
- Certified nurse midwives

**Therapeutic Consultation and Crisis Intervention Providers**
- Developmental Disabilities Agency; or
- Independent Medicaid provider under agreement with the Department or Infant Toddler program

Above providers must also have a Doctoral or Master’s degree in psychology, education, and applied behavioral analysis or in a related discipline. Additional criteria apply.


**Telehealth services as an encounter by a facility are reimbursable if the services are delivered in accordance with the ID Medicaid Telehealth Policy.**


**Geographic Limits**
No reference found.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Live Video</th>
<th>Facility/Transmission Fee</th>
<th>Store-and-Forward</th>
<th>Eligible Services/Specialties</th>
<th>Geographic Limits</th>
<th>Transmission Fee</th>
<th>Remote Patient Monitoring</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td>Conditions</td>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------</td>
<td>---------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Remote Patient Monitoring</td>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider Limitations</td>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Restrictions</td>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Email / Phone / Fax | No reimbursement for telephone, email, text or fax.  
  Reimbursement not available in fee-for-service for telephone, email or fax between a physician and participant.  
  **Source:** ID Administrative Code 16.03.09 Sec. 502 (07b). |
| Consent | A written consent is required, which must disclose the delivery models, provider qualifications, treatment methods, or limitations and telehealth technologies.  
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Out of State Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers of telehealth services must be licensed by the Idaho Board of Medicine or in the case of therapeutic consultation and crisis intervention for children’s developmental disabilities services, providers must meet staff qualifications.</td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Miscellaneous</th>
<th>Technical Requirements:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Video must be provided in real time with full motion video and audio.</td>
</tr>
<tr>
<td></td>
<td>• Transmission of voice must be clear and audible</td>
</tr>
<tr>
<td></td>
<td>• Telehealth services that cannot be provided as effectively as in-person services are not covered.</td>
</tr>
<tr>
<td></td>
<td>• Notation must be made in the patient’s record to designate services delivered via telehealth.</td>
</tr>
</tbody>
</table>

**Provider Requirements**

- Providers at the distant site must disclose to the patient the performing provider’s identity, location, telephone number and Idaho license number.
- Telehealth providers must have a systematic quality assurance and improvement program for telehealth that is documented, implemented and monitored.
- Providers must develop and document evaluation processes and participant outcomes.

See Telehealth Policy for additional documentation requirements.

Services that have been interrupted or terminated early due to equipment problems will not be reimbursed.

Only one provider may be reimbursed for the same service per patient and date of service.


<table>
<thead>
<tr>
<th>Definitions</th>
<th>No reference found.</th>
</tr>
</thead>
</table>

<p>| Requirements | No reference found. |</p>
<table>
<thead>
<tr>
<th>Private Payer Laws</th>
<th>Service Parity</th>
<th>No reference found.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Parity</td>
<td></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

| Professional Regulation/Health & Safety | Definitions | Telehealth services means health care services provided by a provider to a person through the use of electronic communications, information technology, asynchronous store-and-forward transfer or synchronous interaction between a provider at a distant site and a patient at an originating site. Such services include, but are not limited to, clinical care, health education, home health and facilitation of self-managed care and caregiver support.  

**Source:** ID Code Sec. 54-5703(6). |
| Consent | A patient's consent must be obtained.  

**Source:** ID Code Sec. 54-5708. |
| Online Prescribing | Prescribing physicians must have prescriber-patient relationship, which includes a documented patient evaluation adequate to establish diagnoses and identify underlying conditions and/or contraindications to the treatment.  

Prescriptions based solely on online questionnaires or consults outside of an ongoing clinical relationship are prohibited.  

**Source:** ID Code § 54-1733.  

Prescriptions can be issued using telehealth as long as there is an established provider-patient relationship, provided that the prescription is not for a controlled substance unless prescribed in compliance with 21 USC section 802(54)(A).  

If a provider-patient relationship is not yet established, the provider must take appropriate steps to establish the relationship by use of two-way audio and visual interaction, provided that the applicable Idaho community standard of care has been satisfied.  

**Source:** ID Code Sec. 54-5705 & 5707. |
Member of the Interstate Medical Licensure Compact.

Source: ID House Bill 150. ID Code Title 54, Ch. 18.

Member of Nurses Licensure Compact.


Professional Board Telehealth-Specific Regulations

- ID Board of Medicine (Source: IDAPA 22.01.15)
- ID Board of Dentistry (Source: IDAPA 19.01.01 Rule 66)
- ID Board of Psychologist Examiners (Source: IDAPA 24.12.01 Sec. 601)
Medicaid Program: Illinois Medicaid
Program Administrator: Illinois Dept. of Healthcare and Family Services
Regional Telehealth Resource Center: Upper Midwest Telehealth Resource Center
Covers the States of: Illinois, Indiana, Michigan & Ohio
www.umtrc.org

Summary

IL Medicaid reimburses for live video telemedicine and telepsychiatry services for specific providers. A recent law change will require them to expand reimbursement to other behavioral health professions beginning in Jan. 2019. Although IL definitions of telemedicine and telehealth encompass store-and-forward there is no mention of store-and-forward reimbursement. IL Medicaid will provide reimbursement for home uterine monitoring.

Definitions

“Telemedicine” is the use of a telecommunication system to provide medical services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another location.


“Telehealth” means services provided via a telecommunication system.

Source: IL Admin. Code, Title 89,140.403.

“Telehealth is defined as the use of a telecommunication system to provide medical services between places of lesser and greater medical capability and/or expertise, for the purpose of evaluation and treatment. Medical data exchanged can take the form of multiple formats: text, graphics, still images, audio and video. The information or data exchanged can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real-time (asynchronous) through “store-and-forward” applications.”

New Approved Legislation (Effective Jan. 1, 2019)
The Department of Healthcare and Family Services must reimburse psychiatrists, federally qualified health centers, clinical psychologists, clinical social workers, advanced practice registered nurses certified in psychiatric and mental health nursing and mental health professionals and clinicians to provide behavioral health services to recipients via telehealth. The Department can establish by rule the reimbursement criteria, however the Department cannot require a professional be physically present in the same room as the patient for the entire time during which the patient is receiving telehealth services.

Source: SB 3049 (2018), 305 ILCS 5/5-5.25.

Illinois Medicaid will reimburse for live video under the following conditions:

- A physician or other licensed health care professional [or other licensed clinician, mental health professional or qualified mental health professional, for telepsychiatry] must be present with the patient at all times with the patient at the originating site*;
- The distant site provider must be a physician, physician assistant, podiatrist or advanced practice nurse who is licensed by Illinois or the state where the patient is located. For telepsychiatry, it must be a physician who has completed an accredited general psychiatry residency program or an accredited child and adolescent psychiatry residency program;
- The originating and distant site provider must not be terminated, suspended or barred from the Department’s medical programs;
- Telepsychiatry: The distant site provider must personally render the telepsychiatry service;
- Medical data may be exchanged through a telecommunication system. For telepsychiatry it must be an interactive telecommunication system;
- The interactive telecommunication system must, at a minimum, have the capability of allowing the consulting distant site provider to examine the patient sufficiently to allow proper diagnosis of the involved body system. The system must also be capable of transmitting clearly audible heart tones and lung sounds, as well as clear video images of the patient and any diagnostic tools, such as radiographs.
- Telepsychiatry: Group psychotherapy is not a covered telepsychiatry service.

Source: IL Admin. Code Title 89, 140.403.

* According to an All Provider Letter dated Jan. 10, 2018, IL Medicaid will no longer require a physician or other licensed health care professional to be physically present in the same room at all times while the patient is receiving telehealth services.


Appropriate CPT codes must be billed with the GT modifier for telemedicine and telepsychiatry services. See Practitioner Services Handbook Appendices A-10 for telehealth billing examples.


There is no reimbursement for group psychotherapy as a telepsychiatry service.

Source: IL Admin. Code Title 89, 140.403.
For telemedicine services, the distant site provider must be a physician, physician assistant, podiatrist or advanced practice nurse who is licensed by Illinois or the state where the patient is located;

For telepsychiatry, distant site provider must be a physician, licensed health care professional or other licensed clinician, mental health professional or qualified mental health professional.


An encounter clinic serving as the distant site shall be reimbursed as follows:

- If the originating site is another encounter clinic, the distant site encounter clinic shall receive no reimbursement from the Department. The originating site encounter clinic is responsible for reimbursement to the distant site encounter clinic; and
- If the originating site is not an encounter clinic, the distant site encounter clinic shall be reimbursed for its medical encounter. The originating site provider will receive a facility fee.

Encounter Rate Clinics, Federally Qualified Health Centers (FQHC), and Rural Health Clinics, are allowed to render telemedicine services.


Distant Site providers who are encounter clinics may not seek reimbursement for their services when the Originating Site is an encounter clinic, since the clinic is responsible for reimbursement to the Distant Site provider.


Eligible originating site providers include:

- Physician’s office
- Podiatrist’s office
- Local health departments;
- Community mental health centers;
- Outpatient hospitals;

An encounter clinic is eligible as an originating site, and responsible for ensuring and documenting that the distant site provider meets the department’s requirements for telehealth and telepsychiatry services, since the clinic is responsible for reimbursement to the distant site provider.


A physician or other licensed health care professional must be present with the patient at all times at the originating site.*

Source: IL Admin. Code Title 89, 140.403.

* According to an All Provider Letter dated Jan. 10, 2018, IL Medicaid will no longer requires a physician or other licensed health care professional to be physically present in the same room at all times while the patient is receiving telehealth services.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local education agencies may submit telehealth services as a certified expenditure.</strong></td>
</tr>
<tr>
<td>Source: IL Admin. Code Title 89, 140.403(c)(1)(B).</td>
</tr>
<tr>
<td><strong>Non-enrolled providers rendering services as a Distant Site provider shall not be eligible for reimbursement from the department, but may be reimbursed by the Originating Site provider.</strong></td>
</tr>
<tr>
<td><strong>No reference found.</strong></td>
</tr>
<tr>
<td><strong>There is reimbursement for originating site facility fees.</strong></td>
</tr>
<tr>
<td><strong>Eligible facilities include:</strong></td>
</tr>
<tr>
<td>• Physician’s office;</td>
</tr>
<tr>
<td>• Podiatrist’s office;</td>
</tr>
<tr>
<td>• Local health departments;</td>
</tr>
<tr>
<td>• Community mental health centers;</td>
</tr>
<tr>
<td>• Outpatient hospitals.</td>
</tr>
<tr>
<td>Originating site providers who receive reimbursement for the patient’s room and board are not eligible for facility fees.</td>
</tr>
<tr>
<td><strong>Although store-and-forward is included within the definitions of telehealth in IL Medicaid manuals and administrative code (see descriptions below), there are no details provided on store-and-forward reimbursement and other areas of policy indicate that the GT (live video) modifier is required for telehealth services.</strong></td>
</tr>
<tr>
<td>The Illinois Medicaid definition encompasses store-and-forward. “The information or data exchanged can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (asynchronous) through &quot;store-and-forward&quot; applications.”</td>
</tr>
<tr>
<td>Additionally, IL Admin Code encompasses store-and-forward, defining it as the &quot;review the medical case without the patient being present.&quot;</td>
</tr>
<tr>
<td>Source: IL Administrative Code, Title 89, 140.403.</td>
</tr>
<tr>
<td>Service/Eligible Services/Features</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
</tr>
<tr>
<td>IL Medicaid will cover home uterine monitoring with prior approval and when patient meets specific criteria. Payment is only for the items and not for the service.</td>
</tr>
<tr>
<td>Conditions</td>
</tr>
<tr>
<td>- Must be at least 24 weeks gestation; gestation of less than 24 weeks may require additional information</td>
</tr>
<tr>
<td>- Hospitalized for preterm labor at 24-36 weeks</td>
</tr>
<tr>
<td>- Cessation of labor accomplished by administration of tocolytics (terbutaline, procardia, etc.)</td>
</tr>
<tr>
<td>- Discharged to home on oral or subcutaneous tocolytics</td>
</tr>
<tr>
<td>- Multiple gestation pregnancy</td>
</tr>
<tr>
<td>- History of preterm labor and delivery</td>
</tr>
<tr>
<td>- Cervical status change (lengthening or dilation)</td>
</tr>
<tr>
<td>- Cervical effacement</td>
</tr>
<tr>
<td>- Contraction threshold</td>
</tr>
<tr>
<td>- Gravida/para</td>
</tr>
<tr>
<td>Conditions</td>
</tr>
<tr>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>• Covered for diagnosis of pregnancy-induced hypertension, previous pregnancy induced hypertension or pre-eclampsia</td>
</tr>
<tr>
<td>• Blurred vision</td>
</tr>
<tr>
<td>• 24 hour urine results greater than 300 mg of total protein</td>
</tr>
<tr>
<td>• Antihypertensive medications</td>
</tr>
</tbody>
</table>

Will not be covered for patients with a diagnosis of chronic hypertension.


<table>
<thead>
<tr>
<th>Provider Limitations</th>
<th>Provider Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Restrictions</th>
<th>Other Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Email / Phone / Fax</th>
<th>Email / Phone / Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reimbursement for telephone.</td>
<td>No reimbursement for telephone.</td>
</tr>
<tr>
<td>No reimbursement for FAX.</td>
<td>No reimbursement for FAX.</td>
</tr>
<tr>
<td>No reimbursement for text or email.</td>
<td>No reimbursement for text or email.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Consent</th>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
### Medicaid Telehealth Reimbursement

For medical services, the provider rendering the service at the distant site can be a physician, physician assistant, podiatrist or advanced practice nurse, who is licensed by the State of Illinois or by the state where the patient is located.

For psychiatric services, the provider rendering the service at the distant site must be a physician licensed by the State of Illinois, or by the state where the patient is located, who has completed an approved general psychiatry residency program or a child and adolescent psychiatry residency program.


### Out of State Providers

Specific documentation requirements apply for telehealth services. See administrative code for details.

**Source:** IL Administrative Code, Title 89, 140.403(d) (2012). (Accessed Sept. 2018).

### Miscellaneous

“Telehealth services” means the delivery of covered health care services by way of an interactive telecommunication system.

**Source:** IL Insurance Code. Sec. 356z.22.

If an insurer provides coverage for telehealth services, then it shall not:

- Require in-person contact occur between a health care provider and a patient;
- Require the health care provider to document a barrier to an in-person consultation;
- Require telehealth use when it is not appropriate; or
- Require the use of telehealth when the patient chooses an in-person consultation.

**Source:** SB 647 (2014) IL Insurance Code. Sec. 356z.22.

**Newly Approved Legislation (Effective Jan. 1, 2019)**

If an insurer is providing coverage for telehealth services, it must provide coverage for licensed dietitian nutritionists and certified diabetes educators who counsel senior diabetes patients in the senior diabetes patients' home to remove the hurdle of transportation for senior diabetes patients to receive treatment.

**Source:** HB 5351 (2018).

Payers are not required to cover telehealth services, they are only required to meet certain requirements if they choose to do so (see above).

**Source:** IL Insurance Code. Sec. 356z.22.
<table>
<thead>
<tr>
<th>Private Payor Laws</th>
<th>Parity</th>
<th>Payment Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No payment parity.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Regulation/Health &amp; Safety</th>
<th>Definitions</th>
<th>Consent</th>
<th>Online Prescribing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Telehealth” means the evaluation, diagnosis, or interpretation of electronically transmitted patient-specific data between a remote location and a licensed health care professional that generates interaction or treatment recommendations. “Telehealth” includes telemedicine and the delivery of health care services provided by way of an interactive telecommunications system, as defined in subsection (a) of Section 356z.22 of the Illinois Insurance 20 Code.</td>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Telemedicine means the performance of any of the activities listed in Section 49, including, but not limited to, rendering written or oral opinions concerning diagnosis or treatment of a patient in Illinois by a person in a different location than the patient as a result of transmission of individual patient data by telephonic, electronic, or other means of communication. “Telemedicine” does not include the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• periodic consultations between a person licensed under this Act and a person outside the State of Illinois;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• a second opinion provided to a person licensed under this Act;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• diagnosis or treatment services provided to a patient in Illinois following care or treatment originally provided to the patient in the state in which the provider is licensed to practice medicine; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• health care services provided to an existing patient while the person licensed under this Act or patient is traveling.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Source: IL Compiled Statutes, Chapter 225, 150/5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Under the Department of Public Health, telemedicine means the provision of clinical services to patients by physicians and practitioners from a distance via electronic communications.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Source: IL Admin. Code, Title 77, Sec. 250.310</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Regulation/Health &amp; Safety</td>
<td>Cross-State Licensing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Illinois adopted legislation to join the Interstate Medical Licensure Compact.  

**Source:** IL Public Act 099-0076 (2015). |
| Member of Psychology Interjurisdictional Compact (takes effect Jan. 1, 2020).  

**Source:** IL HB 1853 (2018). |
| Must have an IL medical license. An out-of-state person providing a service to a patient in IL through telemedicine submits himself or herself to the jurisdiction of the courts of IL.  

**Source:** IL Compiled Statutes, Chapter 225, 60/49.5. |

<table>
<thead>
<tr>
<th>Miscellaneous</th>
<th></th>
</tr>
</thead>
</table>
| Health professionals authorized by statute to engage in the practice of telehealth to the extent of his or her scope of practice include physicians, physician assistants, optometrists, advanced practice nurses, clinical psychologists licensed in IL and mental health professionals and clinicians authorized by Illinois law to provide mental health services.  

Dentists, occupational therapists, pharmacists, physical therapists, clinical social workers, speech language pathologists, audiologists and hearing instrument dispensers will be added to those allowed to provide telehealth services, effective Jan. 1, 2019.  

**Source:** IL Compiled Statutes, Chapter 225, 150/5. & HB 5070 (2018). |
Indiana Medicaid reimburses for live video telemedicine for certain services and providers. Indiana Medicaid does not reimburse for store-and-forward although store-and-forward can still be used to facilitate other reimbursable services. Indiana Medicaid defines telehealth as including remote patient monitoring (RPM) services and reimburses home health agencies for RPM for patients with diabetes, congestive heart failure and COPD.

Telehealth services are defined as the scheduled remote monitoring of clinical data through technology equipment in the member’s home.


Telemedicine services refer to a specific method of delivery of certain services, including medical exams and consultations, which are already reimbursed by Medicaid. Telemedicine uses video conferencing equipment to allow a medical provider to deliver an exam or other services to a patient at a distant location.

In any telemedicine service, there will be a hub site, a spoke site, an attendant to connect the patient to the specialist at the hub site, a computer or television so that the patient has real-time, interactive and face-to-face communication with the hub specialist/consultant via the interactive television technology.


Telemedicine services are defined as the use of videoconferencing equipment to allow a medical provider to render an exam or other service to a patient at a distant location.


Telemedicine has the same meaning as IC 25-1-9.5-6: "Telemedicine means the delivery of health care services using electronic communications and information technology, including:

- Secure videoconferencing
- Interactive audio-using store-and-forward technology; or
- Remote patient monitoring technology;
<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between a provider in one location and a patient in another location. The term does not include:</td>
</tr>
<tr>
<td>- Audio-only communication</td>
</tr>
<tr>
<td>- A telephone call</td>
</tr>
<tr>
<td>- Electronic mail</td>
</tr>
<tr>
<td>- An instant messaging conversation</td>
</tr>
<tr>
<td>- Facsimile</td>
</tr>
<tr>
<td>- Internet questionnaire</td>
</tr>
<tr>
<td>- Telephone consultation</td>
</tr>
<tr>
<td>- Internet consultation</td>
</tr>
</tbody>
</table>

Source: IN Code 25-1-9.5.

“Telehealth services mean the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across a distance.”

Telemedicine services has the same meaning as “telemedicine” in IN Code 25-1-9.5-6.


Telehealth services means the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across a distance.

Source: 405 IN Admin Code 5-2-27.

<table>
<thead>
<tr>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana Code requires reimbursement for video conferencing for FQHCs, Rural Health Clinics, Community Mental Health Centers, Critical Access Hospitals and a provider determined by the office to be eligible, providing a covered telemedicine service.</td>
</tr>
</tbody>
</table>


A telemedicine encounter requires a distant site, originating site, an attendant to connect the patient to the provider at the distant site, and a computer or television monitor to allow the patient to have real-time, interactive; and face-to-face communication with the distant provider via IATV technology.


The patient must be physically present and participating in the visit.


<table>
<thead>
<tr>
<th>Live Video</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursable CPT codes include:</td>
</tr>
<tr>
<td>- Office or other outpatient visit</td>
</tr>
<tr>
<td>- Psychotherapy</td>
</tr>
<tr>
<td>- Psychiatric diagnostic interviews</td>
</tr>
<tr>
<td>- End Stage Renal Disease (ESRD)</td>
</tr>
</tbody>
</table>

Must use GT Modifier. Payment amount is equal to the current professional fee schedule. Modifier 95 is used for informational purposes.


Providers are encouraged to use the 02 place of service code.

For ESRD related services, IHCP requires at least one monthly visit to be a traditional clinical encounter to examine the vascular access site.

In addition to the services listed above, Medical Policy Manual indicates reimbursement for the following:

- Consultations
- Pharmacologic management


Group and family crisis psychotherapy telemedicine services are covered.


Federally qualified health centers and rural health centers are eligible distant sites as long as services meet both the requirements of a valid encounter and an approved telemedicine service as defined in the IHCP’s telemedicine policy.


Services Not Reimbursed:

- Ambulatory surgical centers;
- Outpatient surgical services;
- Home health agencies or services;
- Radiological services;
- Laboratory services;
- Long-term care facilities, including nursing facilities, intermediate care facilities, or community residential facilities for the developmentally disabled;
- Anesthesia services or nurse anesthetist services;
- Audiological services;
- Chiropractic services;
- Care coordination services with the member not present;
- Durable medical equipment, and home medical equipment providers
- Optical or optometric services;
- Podiatric services;
- Physical therapy services;
- Services billed by school corporations; (only prohibited in policy manual)
- Speech therapy services; (only prohibited in telemedicine module and policy manual)
- Transportation services;
- Services provided under a Medicaid home and community-based waiver.
- Provider to provider consultations (only prohibited in administrative code)

The hub site physician or practitioner must determine if it is medically necessary for a medical professional to be at the spoke site.


Provider types listed under Services Not Reimbursed (under Eligible Services/Specialties section) are not eligible to be reimbursed for telemedicine.

Source: IN Admin. Code, Title 405, 5-38-4.

Reimbursement for telemedicine services is available to the following providers regardless of the distance between the provider and recipient:

- Federally Qualified Health Centers
- Rural Health Clinics
- Community mental health centers
- Critical access hospitals
- A provider, as determined by the office to be eligible, providing a covered telemedicine service


Services may be rendered in an inpatient, outpatient or office setting.


Federally qualified health centers and rural health clinics may be reimbursed if it is medically necessary for a medical professional to be with the member, and the service provided includes all components of a valid encounter code.


For a medical professional to receive reimbursement for professional services in addition to payment for spoke/originating site services, medical necessity must be documented. If it is medically necessary for a medical professional to be with the member at the spoke/originating site, the spoke/originating site is permitted to bill an evaluation and management code in addition to the fee for spoke services. There must be documentation in the patient’s medical record to support the need for the provider’s presence at the spoke site. The documentation is subject to post-payment review.


There is reimbursement for telemedicine services only when the hub and spoke sites are greater than 20 miles apart, except no distance requirements for federally qualified health centers, rural health clinics, community mental health centers and critical access hospitals.*

*According to IHCP Bulletin, effective April 1, 2018 the 20 mile requirement between the distant and originating sites is eliminated.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Live Video</strong></td>
</tr>
<tr>
<td>Facility/Transmission Fee</td>
</tr>
<tr>
<td>Spoke sites are reimbursed a facility fee.</td>
</tr>
<tr>
<td><strong>Policy</strong></td>
</tr>
<tr>
<td>Store-and-Forward</td>
</tr>
<tr>
<td>Indiana Medicaid will not reimburse for store-and-forward services. However, restrictions placed on store-and-forward reimbursement shall not disallow the permissible use of store-and-forward technology to facilitate other reimbursable services.</td>
</tr>
<tr>
<td><strong>Eligible Services/Specialties</strong></td>
</tr>
<tr>
<td>Geographic Limits</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Transmission Fee</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Remote Patient Monitoring</strong></td>
</tr>
<tr>
<td>Policy</td>
</tr>
<tr>
<td>Indiana Code requires Medicaid to reimburse providers who are licensed as a home health agency for telehealth services.</td>
</tr>
<tr>
<td>Source: IN Code, 12-15-5-11(c).</td>
</tr>
</tbody>
</table>
| Conditions | The member must be receiving services from a home health agency. Member must initially have two or more of the following events related to one of the conditions listed below within the previous twelve months:

- Emergency room visit
- Inpatient hospital stay

An emergency room visit that results in an inpatient hospital admission does not constitute two separate events.

Member must have one of the following conditions:

- Chronic obstructive pulmonary disease
- Congestive heart failure
- Diabetes


| Provider Limitations | IN Medicaid required to reimburse home health agencies for telehealth services.

**Source:** IN Code 12-15-5-11.

Reimbursement for home health agencies under certain conditions. A registered nurse must perform the reading of transmitted health information provided from the member in accordance with the written order of the physician.


| Other Restrictions | Treating physician must certify the need for home health services and document that there was a face-to-face encounter with the individual.

**Source:** IN Admin Code, Title 405, 5-16-3.1(e).

Prior authorization is required for all telehealth services and must be submitted separately from other home health service prior authorization requests. Services may be authorized for up to 60 days. See Telehealth Module for additional requirements.


Member must also be receiving or approved for other IHCP home health services.


| Email / Phone / Fax | Telemedicine is not the use of:

- Telephone transmitter for transtelephonic monitoring; or
- Telephone or any other means of communication for consultation from one provider to another.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent</td>
</tr>
</tbody>
</table>
| The spoke site must obtain patient consent. The consent must be maintained at the hub and spoke sites.  


<table>
<thead>
<tr>
<th>Out of State Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous</th>
</tr>
</thead>
</table>
| For patients receiving ongoing telemedicine services, a physician should perform a traditional clinical evaluation at least once a year, unless otherwise stated in policy. The hub physician should coordinate with the patient’s primary care physician.  

| Documentation must be maintained at the distant and originating locations to substantiate the services provided. It must indicate the services were provided via telemedicine and location of the distant and originating sites. Documentation is subject to post-payment review.  

| Medicaid Clarification: Indiana Code does allow a provider to use telemedicine to prescribe a controlled substance to a not-previously examined patient. Opioids, however, cannot be prescribed via telemedicine except in cases in which the opioid is partial agonist and is being used to treat or manage opioid dependence.  


<table>
<thead>
<tr>
<th>Private Payer Laws</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions</td>
</tr>
</tbody>
</table>
| “Telemedicine services” means health care services delivered by use of interactive audio, video, or other electronic media, including:  

- Medical exams and consultations 
- Behavioral health, including substance abuse evaluations and treatment 
- The term does not include delivery of health care services through telephone for transtelephonic monitoring; telephone or any other means of communication for the consultation for one (1) provider to another provider.  

**Source:** IN Code, 27-8-34 & 27-13-1-34. |

<table>
<thead>
<tr>
<th>Requirements</th>
</tr>
</thead>
</table>
| Accident and sickness insurance (dental or vision insurance is excluded) policies and individual or group contracts must provide coverage for telemedicine services in accordance with the same clinical criteria as would be provided for services provided in-person.  

Coverage for telemedicine services may not be subject to a dollar limit, deductible or coinsurance requirement that is less favorable to a covered individual than those applied to the same health services delivered in-person.  

A separate consent cannot be required.  

**Source:** IN Code, 27-8-34-6 & 27-13-7-22. |
### Private Payer Laws

<table>
<thead>
<tr>
<th>Parity</th>
<th>Service Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage must be provided in accordance with the same criteria as would be provided in-person.</td>
<td></td>
</tr>
<tr>
<td><strong>Source:</strong> IN Code, 27-8-34-6 &amp; 27-13-7-22.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No explicit payment parity.</td>
</tr>
</tbody>
</table>

### Professional Regulation/Health & Safety

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Telemedicine means the delivery of health care services using electronic communications and information technology, including:</td>
</tr>
<tr>
<td>• Secure videoconferencing</td>
</tr>
<tr>
<td>• Interactive audio-using store-and-forward technology; or</td>
</tr>
<tr>
<td>• Remote patient monitoring technology;</td>
</tr>
<tr>
<td>Between a provider in one location and a patient in another location. The term does not include:</td>
</tr>
<tr>
<td>• Audio only communication</td>
</tr>
<tr>
<td>• A telephone call</td>
</tr>
<tr>
<td>• Electronic mail</td>
</tr>
<tr>
<td>• An instant messaging conversation</td>
</tr>
<tr>
<td>• Facsimile</td>
</tr>
<tr>
<td>• Internet questionnaire</td>
</tr>
<tr>
<td>• Telephone consultation</td>
</tr>
<tr>
<td>• Internet consultation”</td>
</tr>
<tr>
<td><strong>Source:</strong> IN Code, 25-1-9.5-6 (HB 1263 – 2016).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>A health care provider (as defined in Indiana Code 16-18-2-163(a)) may not be required to obtain a separate additional written health care consent for the provision of telemedicine services.</td>
</tr>
<tr>
<td><strong>Source:</strong> IN Code, 16-36-1-15 (2015).</td>
</tr>
</tbody>
</table>
A documented patient evaluation, including history and physical evaluation adequate to establish diagnoses and identify underlying conditions or contraindications to the treatment recommended or provided, must be obtained prior to issuing prescriptions electronically or otherwise.

Source: IN Admin. Code, Title 844, 5-3-2 (2012).

Indiana has established a pilot program to provide telehealth services to patients in Indiana without the establishment of an in-person patient-physician relationship. The pilot includes the issuance of prescription when medically necessary, with the exception of controlled substances.

Source: IN Code, 25-22.5-14.

A provider may not issue a prescription unless they have established a provider-patient relationship. At a minimum that includes:

- Obtain the patient’s name and contact information;
- Disclose the prescriber’s name and credentials;
- Obtain informed consent from the patient;
- Obtain the patient’s medical history and information necessary to establish a diagnosis;
- Discuss with the patient the diagnosis, evidence for the diagnosis and risks and benefits of the various treatment options;
- Create and maintain a medical record, and with consent notify the patient’s primary care provider of any prescriptions the provider has issued;
- Issue proper instructions for appropriate follow-up care;
- Provide a telemedicine visit summary to the patient, including information that indicates any prescriptions that is being prescribed.

Source: IN Code, 25-1-9.5-7.

A prescription for a controlled substance can be issued for a patient the prescriber has not previously examined if the following conditions are met:

- The prescriber has satisfied the applicable standard of care in the treatment of the patient.
- The issuance of the prescription is within the prescriber’s scope of practice and certification.
- The prescription meets the requirements outline in the following section and it is not an opioid. However, opioids may be prescribed if the opioid is a partial agonist that is used to treat or manage opioid dependence.
- The prescription is not for an abortion inducing drug.
- The prescription is not for an ophthalmic device including glasses, contact lenses or low vision devices.

Additionally, the following conditions must be met:

- The prescriber maintains a valid controlled substance registration under IC 35-48-3.
- The prescriber meets the conditions set forth in 21 U.S.C. 829 et seq.
- The patient has been examined in-person by a licensed Indiana health care provider and the licensed health care provider has established a treatment plan to assist the prescriber in the diagnosis of the patient.
- The prescriber has reviewed and approved the treatment plan described in subdivision (3) and is prescribing for the patient pursuant to the treatment plan.
- The prescriber complies with the requirements of the INSPECT program (IC 35-48-7).


A provider located outside Indiana may not establish a provider-patient relationship with an individual in Indiana unless the provider and the provider’s employer or the provider’s contractor have certified in writing to the Indiana Professional Licensing Agency that the provider agrees to be subject to the jurisdiction of the courts of law of Indiana and Indiana Substantive and Procedural Laws. This certification must be filed by a provider’s employer or contractor at the time of initial certification and renewed when the provider’s license is renewed.

Indiana establishes a telehealth services pilot program utilizing telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, treatment, supervision and information across a distance.

Source: IN Administrative Code 844 Section 5-8-1.
Iowa Medicaid pays for telehealth as long as it meets accepted health care practices and standards. The Medicaid program does not have a definition for telehealth, and therefore it is unknown if the term encompasses store-and-forward or remote patient monitoring.

Department of Human Services is required to adopt rules to provide telehealth coverage under Medicaid. Such rules must provide that in-person contact between a health care professional and a patient is not required as a prerequisite for payment.

Source: IA Senate File 505 (2015), Sec. 12(23), pg. 32-33.

In-person contact between a health care professional and patient is not required for payment for services otherwise covered and appropriately provided through telehealth as long as it meets the generally accepted health care practices and standards prevailing in the applicable professional community.

Services provided in-person or through telehealth shall be treated as equivalent for purposes of reimbursement.

Source: IA Admin Code Sec. 441, 78.55 (249A).

No reference found.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Eligible Providers</th>
<th>Eligible Sites</th>
<th>Geographic Limits</th>
<th>Facility/Transmission Fee</th>
<th>Policy</th>
<th>Eligible Services/Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Video</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Store-and-Forward</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Store-and-Forward</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geographic Limits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transmission Fee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Limitations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Restrictions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Medicaid Telehealth Reimbursement

No reference found.

### Consent

No reference found.

### Out of State Providers

No reference found.

### Miscellaneous

Iowa Medicaid uses the 02 POS code adopted by Medicare.

*Source: IAC 441-79.1(7)b(1).*

### Private Payer Laws

#### Definitions

“Telehealth means the delivery of health care services through the use of interactive audio and video. Telehealth does not include the delivery of health care services through an audio-only telephone, electronic mail message, or facsimile transmission.”

*Source: IA Code 514C.32; House File 2305 (2018).*

#### Requirements

Policies, contracts, or plans providing third-party payment or prepayment of health or medical expenses shall not discriminate between coverage benefits for health care services that are provided in-person and the same health care services provided through telehealth. (Effective Jan. 1, 2019).

*Source: IA Code 514C.32; IA House File 2305 (2018).*
### Private Payer Laws

#### Parity

Health care services must be appropriately delivered by telehealth in accordance with accepted health care practices and standards, including all rules adopted by professional licensing boards.

**Source:** IA Code 514C.32; IA House File 2305 (2018).

#### Payment Parity

No explicit payment parity.

### Professional Regulation/Health & Safety

#### Definitions

**Telecommunications and Technology Commission**

“Telemedicine means use of a telecommunications system for diagnostic, clinical, consultative, data, and educational services for the delivery of health care services or related health care activities by licensed health care professionals, licensed medical professionals, and staff who function under the direction of a physician, a licensed health care professional, or hospital, for the purpose of developing a comprehensive, statewide telemedicine network or education.”

**Source:** IA Admin. Code, 751 7.1(8D).

#### Consent

No reference found.

#### Online Prescribing

Pharmacists are prohibited from dispensing prescription drugs if the pharmacist knows or should have known that the prescription was issued solely on the basis of an Internet-based questionnaire, an Internet-based consult, or a telephone consult, and was completed without a pre-existing patient-provider relationship.

**Source:** IA Admin. Code, 657 8.19(5).

A physician must be physically present with a woman at the time an abortion-inducing drug is provided.

**Source:** IA Admin. Code, 653 13.10(3).
Iowa adopted the Federation of State Medical Board (FSMB)’s model language for an interstate medical licensure compact.

**Source:** IA Admin. Code, 657.8.19(5).

Member of Physical Therapy Compact.

**Source:** HF 2296 (2018). PTC States.

Member of Nurse Licensure Compact.

**Source:** Current NLC States and Status. NCSBN. (Accessed Sept. 2018).

**Professional Board Telehealth-Specific Regulations**

- IA Board of Medicine (**Source:** IA Admin Code Sec. 653.13.11)
- IA Board of Physical and Occupational Therapists (**Source:** IA Admin Code Sec. 645-201.3 & 645-208.3)
Kansas Medicaid covers live video telemedicine for certain services. Additionally, they also cover remote patient monitoring that is in real-time through home health agencies and with prior authorization.

A recently passed piece of legislation (HB 2028) requires all insurers (including Medicaid) to cover medically necessary services, subject to the terms and conditions of the contract. Medicaid specifically must provide reimbursement for speech language pathology services and audiology services. However, the bill does not go into effect until Jan. 1, 2019.

“Telemedicine is the use of communication equipment to link health care practitioners and patients in different locations. This technology is used by health care providers for many reasons, including increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers.”


Recently Approved Legislation (Effective Jan. 1, 2019)
“Telemedicine,” including “telehealth,” means the delivery of healthcare services or consultations while the patient is at an originating site and the healthcare provider is at a distant site. Telemedicine shall be provided by means of real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support healthcare delivery, that facilitate the assessment, diagnosis, consultation, treatment, education and care management of a patient’s healthcare. “Telemedicine” does not include communication between:

(A) Healthcare providers that consist solely of a telephone voice-only conversation, email or facsimile transmission; or
(B) a physician and a patient that consists solely of an email or facsimile transmission.

Recently Approved Legislation (Effective Jan. 1, 2019)

Insurers (including Medicaid) cannot exclude from coverage a service solely because the service is provided through telemedicine, rather than in-person contact or based upon the lack of a commercial office for the practice of medicine, when such service is delivered by a healthcare provider.


Kansas Medicaid will reimburse for live video for certain services.


Eligible services:

- Office visits;
- Individual psychotherapy;
- Pharmacological management services.

The consulting expert must bill with the 02 place of service code. The GT modifier is not required except for services provided on or before December 31, 2017. Patient must be present at originating site.

See manual for list of acceptable CPT codes. Telemedicine will be reimbursed at the same rate as face-to-face services.

KMAP does not recognize CPT Codes 99241-99245 and 99251-99255.


Mental health assessment can be delivered either face-to-face or through telemedicine.


Recently Approved Legislation (Effective Jan. 1, 2019)

Kansas Medicaid is required to provide coverage for speech-language pathology services and audiology services provided by a speech-language pathologist or audiologist licensed by Kansas department for aging and disability services by means of telehealth if such services would be covered when delivered in-person. The Department of Health and Environment is required to prepare an impact report that assesses the financial and social effects of this coverage on or before January 13, 2020.


No reference found.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Sites</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Live Video</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Geographic Limits</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Facility/Transmission Fee</strong></td>
</tr>
<tr>
<td>The originating site may bill code Q3014 for the originating site fee with the appropriate POS code.</td>
</tr>
<tr>
<td><strong>Policy</strong></td>
</tr>
<tr>
<td>Kansas Medicaid requires the patient to be present at the originating site indicating store-and-forward will not be reimbursed.</td>
</tr>
<tr>
<td><strong>Store-and-Forward</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Eligible Services/Specialties</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>Kansas Medicaid will reimburse for home telehealth. The policy states:</td>
</tr>
<tr>
<td>“Home telehealth uses real-time, interactive, audio/video telecommunication equipment to monitor patients in the home setting, as opposed to a nurse visiting the home. This technology may be used to monitor the beneficiary for significant changes in health status, provide timely assessment of chronic conditions and provide other skilled nursing services.”</td>
</tr>
</tbody>
</table>
Providers must submit literature to the fiscal agent’s Provider Enrollment team pertaining to the telecommunication equipment the agency has chosen that will allow thorough physical assessments such as: assessment of edema, rashes, bruising, skin conditions, and other significant changes in health status.

Providers must enroll and satisfy demonstration requirements to be enrolled.

Providers are eligible for reimbursement of home telehealth services that meet the following criteria:

- Prescribed by a physician;
- Considered medically necessary;
- Signed beneficiary consent for telehealth services;
- Skilled nursing service;
- Does not exceed program limitations (two visits per week for non-Home and Community Based Services beneficiaries)

Prior authorization required.


HCBS beneficiaries eligible for face-to-face skilled nursing visits provided by a home health agency may receive home telehealth visits with documentation of medical necessity and prior authorization (PA). The PA must include units to cover the duration and frequency of home telehealth visits.

Oral medication administration or monitoring is not considered skilled care.


No reimbursement for email.
No reimbursement for telephone.
No reimbursement for FAX.


Written consent for telehealth home services is required.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Out of State Providers</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Private Payor Laws</th>
<th>Definitions</th>
<th>Requirements</th>
</tr>
</thead>
</table>
| Recently Passed Legislation (Effective Jan. 1, 2019) | "Telemedicine," including “telehealth,” means the delivery of healthcare services or consultations while the patient is at an originating site and the healthcare provider is at a distant site. Telemedicine shall be provided by means of real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support healthcare delivery, that facilitate the assessment, diagnosis, consultation, treatment, education and care management of a patient's healthcare. "Telemedicine" does not include communication between:

(A) Healthcare providers that consist solely of a telephone voice-only conversation, email or facsimile transmission; or
(B) a physician and a patient that consists solely of an email or facsimile transmission.

**Source:** *KS HB 2028 (2018).* |

Insurers cannot exclude from coverage a service solely because the service is provided through telemedicine, rather than in-person contact or based upon the lack of a commercial office for the practice of medicine, when such service is delivered by a healthcare provider.

No additional documentation for telemedicine is required.

**Source:** *KS HB 2028 (2018).* |

<table>
<thead>
<tr>
<th>Parity</th>
<th>Service Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment can be limited to only services that are medically necessary, subject to the terms and conditions of the covered individual’s health benefits plan.</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** *KS HB 2028 (2018).*
Payment for covered services delivered through telemedicine may be established by an insurance company, nonprofit health service corporation, nonprofit medical and hospital service corporation or health maintenance organization in the same manner as payment or reimbursement for covered services that are delivered via in-person contact are established.

**Source:** KS HB 2028 (2018).

---

**Recently Passed Legislation (Effective Jan. 1, 2019)**

“Telemedicine,” including “telehealth,” means the delivery of healthcare services or consultations while the patient is at an originating site and the healthcare provider is at a distant site. Telemedicine shall be provided by means of real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support healthcare delivery, that facilitate the assessment, diagnosis, consultation, treatment, education and care management of a patient’s healthcare. “Telemedicine” does not include communication between:

(A) Healthcare providers that consist solely of a telephone voice-only conversation, email or facsimile transmission; or
(B) a physician and a patient that consists solely of an email or facsimile transmission.

**Source:** KS HB 2028 (2018).

---

**Consent**

No reference found.

---

**Online Prescribing**

Physicians must have a pre-existing patient-prescriber relationship. Physicians are prohibited from prescribing drugs on the basis of an internet-based questionnaire or consult, or telephone consult.

**Source:** KS Admin. Regs., Sec. 68-2-20.

Telemedicine may be used to establish a valid provider-patient relationship.

The State Board of Healing Arts in consultation with the state board of pharmacy and nursing, must adopt rules and regulations related to the prescribing of drugs, including controlled substances via telemedicine by Dec. 31, 2018.

**Source:** KS HB 2028 (2018).

---

**Cross-State Licensing**

Kansas adopted the Federation of State Medical Board (FSMB)’s model language for an interstate medical licensure compact.

**Source:** House Bill 2615 – 2015.

Member of Nurses Licensure Compact.

**Source:** Current NLC States and Status. NCSBN. Accessed Sept. 2018.
No reference found.
Kentucky

Medicaid Program: Kentucky Medicaid
Program Administrator: Kentucky Dept. for Medicaid Services
Regional Telehealth Resource Center: Mid-Atlantic Telehealth Resource Center
Covers the States of: Delaware, Kentucky, Maryland, North Carolina, New Jersey, Pennsylvania, Virginia, and West Virginia as well as the District of Columbia

www.matrc.org

Recently Adopted Legislation (Effective Jul. 1, 2019)
KY Medicaid is required to reimburse for covered services provided to a Medicaid recipient through telehealth. The Department must establish requirements for telehealth coverage and reimbursement which are equivalent to the coverage for the same service provided in-person unless the telehealth provider and the Medicaid program agree to a lower reimbursement rate for telehealth services, or the Department establishes a different reimbursement rate.

KY Medicaid is restricted from doing the following:

- Requiring a Medicaid provider to be physically present with a Medicaid recipient, unless the provider determines that it is medically necessary to perform those services in-person;
- Requiring prior authorization, medical review or administrative clearance for telehealth that would not be required if a service were provided in-person;
- Requiring a Medicaid provider to be employed by another provider or agency in order to provide telehealth services that would not be required if that service were provided in-person;
- Require demonstration that it is necessary to provide services to a Medicaid recipient through telehealth;
- Restrict or deny coverage of telehealth based solely on the communication technology or application used to deliver the telehealth service; OR
- Require a Medicaid provider to be part of a telehealth network.

Source: KY Revised Statutes. 205.5591.

Definitions

Recently Adopted Legislation (Effective Jul. 1, 2019)
Telehealth means the delivery of health care-related services by a Medicaid provider who is a health care provider licensed in Kentucky to a Medicaid recipient 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. 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 Medicaid recipient’s medical history prior to the telehealth encounter; shall not include the delivery of services through electronic mail, text chat, facsimile or standard audio-only telephone call; and shall be delivered over a secure communications connection that complies with federal HIPAA.

“Telehealth consultation means a medical or health consultation, for purposes of patient diagnosis or treatment, that meets the definition of telehealth in this section.”

Source: KY Revised Statutes. 205.510.
Telehealth means two-way, real time interactive communication between a patient and a physician or practitioner located at a distant site for the purpose of improving a patient’s health through the use of interactive telecommunication equipment that includes, at a minimum, audio and video equipment.

Source: KY 907 KAR 1:055E.

“Telemedicine” means two-way, real time interactive communication between a patient and a physician or practitioner located at a distant site for the purpose of improving a patient’s health through the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Source: KY 907 KAR 9:005.

“Telehealth medical services: The originating-site or spoke site is the location of the eligible Kentucky Medicaid recipient at the time the telehealth service is being furnished via an interactive telehealth service communications system. The distant or hub site is the location of the provider and is considered the place of service. An interactive telehealth service communication system includes interactive audio and video equipment permitting two-way real time interactive communication between the patient and the practitioner at the originating and distant-sites.”


Kentucky Medicaid will reimburse for a “telehealth consultation”, which includes live video.

Source: KY Revised Statutes 205.559.

Reimbursement shall not be denied solely because an in-person consultation between a provider and a patient did not occur.

Source: KY Revised Statutes § 205.559. (Effective until Jul. 1, 2019).

Telehealth services, provided at an originating site is covered to the same extent the service and provider are covered when furnished face-to-face.


Telehealth consultation requires two-way interactive video, referral by a health care provider and a referral by a recipient's lock-in provider (if applicable).


Coverage is limited to:

- Consultation
- Mental health evaluation and management services
- Individual and group psychotherapy
- Pharmacologic management
- Psychiatric/psychological/mental health diagnostic interview examinations
- Individual medical nutrition therapy consultation services

Medicaid Telehealth Reimbursement

Additional Covered Services in Administrative Regulations:

- Individual diabetes self-management training
- Occupational Therapy evaluation or treatment (provided by OTs)
- Physical therapy evaluation or treatment (provided by PTs)
- Speech therapy evaluation or treatment (provided by speech therapist)
- Neurobehavioral status examination
- End-stage renal disease monitoring, assessment or counseling consultation

All telehealth services have additional restrictions.


Telehealth services are subject to utilization review.


Prior authorization is needed for select telehealth procedures.


Covered Services in a Community Mental Health Center

- Psychiatric diagnostic interview examination
- Pharmacologic management
- Group psychotherapy
- Mental health evaluation or management emergency services
- Mental health assessment
- Individual psychotherapy


Live video GT modifier for “telehealth consultation” accepted by Medicaid.


Eligible Providers for services NOT in a Community Mental Health Center:

- A psychiatrist;
- A licensed clinical social worker;
- A psychologist;
- A licensed professional clinical counselor;
- A licensed marriage and family therapist;
- A physician;
- An APRN;
- Speech-language pathologist;
- Occupational therapist;
- Physical therapist; or
- Licensed dietitian or certified nutritionist;
- Registered nurse or dietitian
- Optometrist (not in Medicaid SPA, only listed in regulation)
- Chiropractor (not in Medicaid SPA, only listed in regulation)
- Physician assistant (not in Medicaid SPA, only listed in regulation)
Eligible providers for services in a Community Mental Health Center:

- A psychiatrist;
- A physician;
- Psychologist with a license in accordance with KRS 319.010(6);
- A licensed marriage and family therapist;
- A licensed professional clinical counselor;
- A psychiatric medical resident;
- A psychiatric registered nurse;
- A licensed clinical social worker;
- An advanced practice registered nurse

Restrictions apply for all professionals.


KY Medicaid does not cover other forms of store-and-forward, as a telehealth consultation requires a two-way interactive video.

_Source: KY Admin. Regs. Title, 907, 3:170, Sec. 1(47)._
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Store-and-Forward</strong></td>
</tr>
<tr>
<td>Eligible Services/Specialties</td>
</tr>
</tbody>
</table>
| Kentucky reimburses for tele-radiology but there is no other reference to reimbursing for other specialties.  
| Beginning Jul. 1, 2019 KY Medicaid is required to reimburse telehealth consultations, which encompasses store-and-forward.  
  Source: KY Revised Statutes 205.559.  |
| Geographic Limits                |
| No reference found.              |
| Transmission Fee                 |
| No reference found.              |
| **Remote Patient Monitoring**    |
| Policy                           |
| Not later than July 1, 2017 the department must establish a pilot project which creates coverage provisions and reimbursement criteria for telemonitoring services. CCHP has found no information regarding the commencement of this pilot.  
| Conditions                       |
| No reference found.              |
| Provider Limitations             |
| No reference found.              |
Remote Patient Monitoring

No reference found.

Email / Phone / Fax

No reimbursement for email.
No reimbursement for telephone.
No reimbursement for FAX.

Source: KY Revised Statutes § 205.559 (2)(b).

Consent

The Cabinet must ensure informed consent.

Source: KY Statute Sec. 205.5591 (2).

Before providing a telehealth consultation, providers must document written patient informed consent.

This includes:

- The patient may refuse the telehealth consultation at any time without affecting the right to future care or treatment, and without risking the loss or withdrawal of a benefit to which the patient is entitled;
- The recipient shall be informed of alternatives to the telehealth consult;
- The recipient shall have access to medical information resulting from the telehealth consult as provided by law;
- The dissemination, storage, or retention of an identifiable recipient image or other information from the telehealth consult shall comply with all state and federal confidentiality laws and regulations;
- The patient shall have the right to be informed of the parties who will be present at the spoke site and the hub site during the telehealth consult, and shall have the right to exclude anyone from either site;
- The patient shall have the right to object to the videotaping of a telehealth consult.


Out of State Providers

KY Medicaid program required to only allow providers licensed in Kentucky to receive reimbursement for telehealth services.

Source: KY Statute Sec. 205.5591 (4).
The Cabinet is required to do the following:

- Develop policies and procedures to ensure the proper use and security for telehealth, including but not limited to confidentiality and data integrity, privacy and security, informed consent privileging and credentialing, reimbursement and technology;
- Promote access to health care provided via telehealth;
- Maintain a list of Medicaid providers who may deliver telehealth services of Medicaid recipients throughout the commonwealth;
- Require that specialty care be rendered by a health care provider who is recognized and actively participating in the Medicaid program; and
- Require that any required prior authorization requesting a referral or consultation for specialty care be processed by the patient’s primary care provider and that any specialist coordinates care with the patient’s primary care provider.

Source: KY Statute Sec. 205.5591 (2).

Providers must be approved through the Kentucky e-Health/Telehealth Network Board. Must be approved member of KY telehealth network.


For FQHCs and RHCs a “visit” is defined as occurring in-person or via telehealth.

Source: KY 907 KAR 1:055 (37).

The department reimburses a telehealth provider eligible for reimbursement for a telehealth consultation an amount equal to the amount paid for a comparable in-person service if the service was provided by a physician, and if the service was provided by an advanced practice registered nurse. This is not the case if the service was provided and billed through a FQHC, FQHC look-alike, RHC or primary care center, a hospital outpatient department, home health agency or nursing home. Reimbursement for a telehealth consultation provided by a practitioner who is employed by a provider or is an agent of a provider is a matter between the provider and practitioner. A managed care organization is not obligated to reimburse the same amount as the department reimburses.

Source: KY Admin. Regs. Title, 907, 3:170, Sec. 5.

Recently Adopted Legislation (Effective Jul. 1, 2019)

Telehealth means the delivery of health care-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. 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; Shall not include the delivery of services through electronic mail, text chat, facsimile, or standard audio-only telephone call; and Shall be delivered over a secure communications connection that complies with HIPAA.

Source: KY Revised Statute Sec. 304.17A-005.
Effective until Jul. 1, 2019
Kentucky law states that insurers may not deny coverage because it is “provided through telehealth and not provided through face-to-face consultation” therefore requiring reimbursement for live video. A health benefit plan may provide coverage for a consultation at a site not within the telehealth network at the discretion of the insurer.


Recently Adopted Legislation (Effective Jul. 1, 2019)
A health benefit plan shall reimburse for covered services provided to an insured person through telehealth. A health benefit plan shall not:

- Require a provider be physically present with a patient or client, unless the provider determines that it is necessary to perform those services in-person;
- Require prior authorization, medical review, or administrative clearance for telehealth that would not be required if a service were provided in-person;
- Require demonstration that it is necessary to provide services to a patient or client through telehealth;
- Require a provider to be employed by another provider or agency in order to provide telehealth services that would not be required if that service were provided in-person;
- Restrict or deny coverage of telehealth based solely on the communication technology or application used to deliver the telehealth services; or
- Require a provider to be part of a telehealth network.

A provider must be licensed in Kentucky to receive reimbursement for telehealth services.

Source: KY Revised Statute Sec 304.17A-138.

Parity

Service Parity

Payers shall not exclude services solely because the service is provided through telehealth.


Recently Adopted Legislation (Effective Jul. 1, 2019)
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.

Source: KY Revised Statutes § 304.17A-138.
Dietitians or Nutritionists & Jail Standards (Department of Corrections)

"Telehealth means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education."

Source: KY Revised Statutes § 310.200 & KAR Title 501, Ch. 13, Sec. 010.

Consent

The treating physician who delivers or facilitates the telehealth service shall obtain the informed consent of the patient before services are provided.


Patient consent must be obtained by:

- Physicians;
- Chiropractors;
- Nurses;
- Dentists;
- Dieticians or nutritionist;
- Pharmacist;
- Psychologists or psychological associate;
- Occupational therapists;
- Optronist;
- Physical therapists;
- Speech language pathologists or audiologists;
- Social workers;
- Marriage/family therapists;
- Respiratory care practitioners.

Source: Cited in various sections of law. Originated from HB 177 (2000).

Also see listing of Professional Board Regulation in Miscellaneous section for regulatory requirements for informed consent by profession.

The Board of Speech Language Pathology and Audiology requires their licensees to inform the client in writing, in an initial in-person meeting, about:

- The limitations of using technology in the provision of telepractice;
- Potential risks to confidentiality of information due to technology in the provision of telepractice;
- Potential risks of disruption in the use of telepractice;
- When and how the licensee will respond to routine electronic messages;
- In what circumstances the licensee will use alternative communications for emergency purposes;
- Who else may have access to client communications with the licensee;
- How communications can be directed to a specific licensee;
- How the licensee stores electronic communications from the client; and
- That the licensee may elect to discontinue the provision of services through telehealth.

Source: KY 201 KAR 17.110.
Prior to prescribing in response to any communication transmitted or received by computer or other electronic means, physicians must establish a proper physician-patient relationship. This includes:

- Verification that the person requesting medication is in fact who the patient claims to be;
- Establishment of a documented diagnosis through the use of accepted medical practices;
- Maintenance of a current medical record.

An electronic, online, or telephone evaluation by questionnaire are inadequate for the initial or any follow-up evaluation.

Source: KY Revised Statutes § 311.597.

A “good faith prior examination” (needed to establish a physician-patient relationship) can be done through telehealth.

Source: KY Rev. Statute 218A.010.

The Board of Speech Language Pathology and Audiology does not allow for the establishment of a practitioner-patient relationship via telehealth. They require an in-person meeting to occur first. A practitioner-patient relationship is required to issue a prescription.

Source: KY 201 KAR 17:110.

A physician performing or inducing an abortion shall be present in-person and in the same room with the patient. The use of telehealth shall not be allowed in the performance of an abortion.

Source: KY Revised Statute Sec. 311.728.

A provider must be licensed in Kentucky with the exception of persons who, being nonresidents of Kentucky and lawfully licensed to practice medicine or osteopathy in their states of actual residence, infrequently engage in the practice of medicine or osteopathy within this state, when called to see or attend particular patients in consultation and association with a Kentucky-licensed physician.

Source: KY Revised Statutes § 311.560.

Member of Nurse Licensure Compact.


Member of Physical Therapy Compact.


Professional Board Telehealth-Specific Regulations

- Speech Language Pathology and Audiology (Source: Title 201, Ch. 17, Sec. 110)
- Board of Optometric Examiners (Source: Title 201, Ch. 5, Sec. 055)
- Physical Therapy (Source: Title 201, Ch. 22, Sec. 160)
- Dieticians and Nutritionists (Source: Title 201, Ch. 33, Sec. 070)
- Applied Behavior Analysis (Source: Title 201, Ch. 43, Sec. 10)
- Nursing (Source: Title 201, Ch. 20, Sec. 520)
- Board of Psychology (Source: Title 201, Ch. 26, Sec. 310)
- Occupational Therapy (Source: Title 201, Ch. 28, Sec. 235)
Live video telemedicine is covered for distant site providers enrolled in Louisiana Medicaid. There is no reimbursement for the originating site. Activity and sensor monitoring, health status monitoring and medication dispensing and monitoring are forms of remote patient monitoring that are covered by Louisiana Medicaid. There is no reference to store-and-forward.

“Telemedicine is the use of medical information exchanges from one site to another via electronic communications to improve a recipient’s health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient at the originating site, and the physician or practitioner at the distant site.”


Louisiana Medicaid reimburses the distant site for services provided via telemedicine.

Covered services must be identified on claims submissions by appending the modifier "GT".


Louisiana Medicaid reimburses for "services provided via an interactive audio and video telecommunications system."

Source: LA Register, Volume 31, 2032 (2012).
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Eligible Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>The distant site provider must be enrolled as a Louisiana Medicaid provider to receive reimbursement for covered services.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligible Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Geographic Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility/Transmission Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louisiana Medicaid only reimburses the distant site provider.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louisiana Medicaid will not provide reimbursement for store-and-forward based upon the definition of “telemedicine” which describes telemedicine as including “audio and video equipment permitting two-way, real time interactive communication” therefore excluding store-and-forward.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Store-and-Forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligible Services/Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>
Under the Community Choices Waiver, Louisiana Medicaid will reimburse an installation fee and a monthly maintenance fee for:

- TeleCare Activity and Sensor Monitoring,
- Health status monitoring, and
- Medication dispensing and monitoring.

Personal Emergency Response System (PERS) is also reimbursed under Community Choices Waiver, which sends alerts when emergency services are needed by the recipient.

**Activity and Sensor Monitoring**
At a minimum the system must:

- Monitor the home’s points of egress and entrance;
- Detect falls;
- Detect movement or lack of movement;
- Detect whether doors are opened or closed; and
- Provide a push button emergency alert system.

**Health Status Monitoring**
Could be beneficial for patient with chronic conditions for monitoring weight, oxygen saturation measurements and vital signs.

**Medication Dispensing and Monitoring**
A remote monitoring system that is pre-programed to dispense and monitor the recipient’s compliance with medication therapy. Provider or caregiver is notified when there are missed doses.

**Standards**
Providers of assistive devices and medical equipment must be a licensed home health agency.

Certain standards apply for the medical equipment and supplies used (see manual).

**Conditions**
Health status monitoring: May be beneficial to individuals with congestive heart failure, diabetes or pulmonary disease.

**Services must be based on verified need.**
Medicaid Telehealth Reimbursement

**Provider Limitations**

Providers must meet the following requirements:

- Be UL listed/certified or have 501(k) clearance;
- Be web-based;
- Be compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA);
- Have recipient specific reporting capabilities for tracking and trending;
- Have a professional call center for technical support based in the United States; and
- Have on-going provision of web-based data collection for each recipient, as appropriate. This includes response to recipient self-testing, manufacturer’s specific testing, self-auditing and quality control.


**Limitations**

- Services must be pre-approved.
- Services must be based on verified need.
- Benefit must be determined by an independent assessment (done by appropriate professional who has no fiduciary relationship with the manufacturer, supplier or vendor) on any item that costs over $500.
- All items must reduce reliance on other Medicaid state plan or waiver services.
- All items must meet applicable standards of manufacture, design and installation.
- The items must be on the Plan of Care developed by the support coordinator.

A recipient is not able to receive simultaneously Telecare Activity and Sensor Monitoring services and traditional PERS services.

Where applicable, recipients must use Medicaid State Plan, Medicare or other available payers first.


**Email / Phone / Fax**

No reference found.

**Consent**

No reference found.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of State Providers</td>
</tr>
<tr>
<td>The recipients record at both the originating and distant site should reflect that the service was provided using telemedicine.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Private Payer Laws</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement must be made to the originating site physician if he/she is physically present during the exam and interact with the distant-site physician.</td>
</tr>
<tr>
<td>Originating-site physician fees shall be at least 75 percent of the normal fee for an intermediate office visit.</td>
</tr>
<tr>
<td>No reference found for distant-site physician reimbursement.</td>
</tr>
<tr>
<td><strong>Source:</strong> LA Revised Statutes 22:1821 (2012).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Parity</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Originating-site physician fees shall be at least 75 percent of the normal fee for an intermediate office visit.</td>
</tr>
<tr>
<td><strong>Source:</strong> LA Revised Statutes 22:1821 (2012).</td>
</tr>
</tbody>
</table>
Medical Board
“Telemedicine is the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data using interactive telecommunication technology that enables a health care practitioner and a patient at two locations separated by distance to interact via two-way video and audio transmissions simultaneously. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient, or a true consultation as may be defined by rules promulgated by the board pursuant to the Administrative Procedure Act, constitutes telemedicine.”

Source: LA Revised Statutes 37:1262.

Public Health & Safety
Telehealth means a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from healthcare providers. Telehealth allows services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store-and-forward transfers.

Source: LA Revised Statutes HB 1Title 40 Sec. 1223.3 & Title 46, Part LXXV, Ch. 1, Sec. 103 (Speech Language Pathology/Audiology).

Speech-Language Pathology & Audiology
Telehealth is a mode of delivering audiology and speech-language pathology services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education care management, and self-management of clients at a distance from the audiologist or speech-language pathologist provider services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

Source: Title 46, Part LXXV, Ch. 1, Sec. 103 (Speech Language Pathology/Audiology).

Physician’s Use of Telemedicine in Practice
Telemedicine - the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data by a physician using interactive telecommunication technology that enables a physician and a patient at two locations separated by distance to interact via two-way video and audio transmissions simultaneously. Neither an electronic mail message between a physician and a patient, or a true consultation constitutes telemedicine for the purposes of this Part. A physician practicing by telemedicine may utilize interactive audio without the requirement of video if, after access and review of the patient’s medical records, the physician determines that he or she is able to meet the same standard of care as if the healthcare services were provided in-person.


Physicians must inform telemedicine patients of the relationship between the physician and patient, and the role of any other health care provider with respect to management of the patient. The patient may decline to receive telemedicine services and withdraw from such care at any time.

Louisiana law requires that a physician who uses telemedicine establish a proper physician-patient relationship. Physicians must:

- Verify the identity of the patient;
- Conduct an appropriate exam;
- Establish a proper diagnosis;
- Discuss the diagnosis and risks and benefits of various treatment options;
- Ensure the availability of follow up care;
- Create and/or maintain a medical record.


Telemedicine, including the issuance of any prescription via electronic means, shall be held to the same prevailing and usually accepted standards of medical practice as those in traditional, face-to-face settings.

An online, electronic or written mail message, or a telephonic evaluation by questionnaire or otherwise, does not satisfy the standards of appropriate care.

To establish a physician-patient relationship an in-person visit is not required if the technology is sufficient to provide the physician the pertinent clinical information.

No physician shall authorize or order the prescription, dispensation or administration of any controlled substance unless:

a. the physician has had at least one in-person visit with the patient within the past year; provided, however, the requirement for an in-person visit shall not apply to a physician who holds an unrestricted license to practice medicine in LA and who practices telemedicine upon any patient being treated at a healthcare facility that is required to be licensed pursuant to the laws of LA and which holds a current registration with the U.S. Drug Enforcement Administration;
b. the prescription is issued for a legitimate medical purpose;
c. the prescription is in conformity with the standard of care applicable to an in-person visit; and
d. the prescription is permitted by and in conformity with all applicable state and federal laws and regulations.

_Source: LA Admin. Code 46:XLV.408, Ch. 7503-05 & 7513.

For physicians practicing telemedicine and treating a patient at a healthcare facility that is required to be licensed according to the laws of LA and holds a current registration with the US Drug Enforcement Administration:

- Physician must use the same standard of care as in-person.
- Physician must be authorized to prescribe any controlled dangerous substance without necessity of conducting an appropriate in-person patient history or physical examination.
- Physician shall not be subject to any regulation prohibition or restriction on the use of telemedicine that is more restrictive than those that are otherwise applicable to their entire profession.


No physician practicing telemedicine can prescribe a controlled dangerous substance prior to conducting an appropriate in-person patient history or physical examination of the patient.

_Source: LA Revised Statutes 37:1271(B)(3).
A telemedicine license may be issued to out-of-state physicians, as long as they hold a full and unrestricted license in another state or U.S. territory.

Out-of-state telemedicine providers cannot open an office, meet with patients or receive calls from patients within Louisiana.


LA state agencies and professional boards can regulate the use of telehealth including licensing of out-of-state healthcare providers.

Source: LA Revised Statutes 40:1223.4.

A physician may practice in the state with a full license, or hold a telemedicine permit.


Member of Physical Therapy Compact.


Member of Nurse Licensure Compact.


Professional Board Telehealth-Specific Regulations

- Louisiana Medical Board (Title 46, Part XLV, Subpart 1, Subchapter C, Ch. 75)
- Speech Language Pathology and Audiology (Title 46, Part LXXV, Ch. 1, Sec. 130).

Louisiana has specific standards for its telemedicine physicians.

Maine Medicaid (MaineCare) reimburses for live video telehealth under certain conditions, and remote patient monitoring for patients with certain risk factors. Although their definition of telehealth is broad enough to include store-and-forward, there is no mention of store-and-forward reimbursement within their policies.

Telehealth as it pertains to the delivery of health care services, means the use of interactive real-time visual and audio or other electronic media for the purpose of consultation and education concerning and diagnosis, treatment, care management and self-management of a patient’s physical and mental health and includes real-time interaction between the patient and the telehealth provider, synchronous encounters, asynchronous encounters, store-and-forward transfers and remote patient monitoring. “Telehealth” includes telephonic services when interactive telehealth services are unavailable or when a telephonic service is medically appropriate for the underlying covered service.

If the Member is eligible for the underlying covered service and providing it via telehealth is medically appropriate and is of comparable quality as if it had been delivered in-person, the telehealth service is eligible for reimbursement.

No reimbursement for communication between health care providers when the member is not present at the originating site.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Eligible Services / Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a specific list of codes provided in the manual.</td>
<td>Non-Covered services include:</td>
</tr>
<tr>
<td></td>
<td>• Medical equipment</td>
</tr>
<tr>
<td></td>
<td>• Personal care aide</td>
</tr>
<tr>
<td></td>
<td>• Pharmacy services</td>
</tr>
<tr>
<td></td>
<td>• Assistive technology services</td>
</tr>
<tr>
<td></td>
<td>• Non-emergency medical transportation</td>
</tr>
<tr>
<td></td>
<td>• Ambulance services</td>
</tr>
<tr>
<td></td>
<td>• Services that require physical contact</td>
</tr>
<tr>
<td></td>
<td>• Any service medically inappropriate for telehealth services</td>
</tr>
<tr>
<td></td>
<td>See manual for full list of exclusions.</td>
</tr>
<tr>
<td></td>
<td><strong>Source:</strong> MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4., p. 5-6. (Accessed Sept. 2018).</td>
</tr>
</tbody>
</table>

| | Eligible Providers |
| | A health care provider must also be: |
| | • Acting within the scope of his or her license |
| | • Enrolled as a MaineCare provider; and |
| | • Otherwise eligible to deliver the underlying Covered Service |
| | **Source:** MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4.03., p. 3. (Accessed Sept. 2018). |
| | If approved by HRSA and the state, a FQHC, RHC, or IHC may serve as the provider site and bill under the encounter rate. |
| | **Source:** MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4.p. 10. (Apr. 9, 2018). (Accessed Sept. 2018). |

| | Eligible Sites |
| | FQHCs, RHCs or IHCs may be originating sites. |
| | **Source:** MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4., p. 10. (Apr. 9, 2018). (Accessed Sept. 2018). |

| | Geographic Limits |
| | No reference found. |

| | Facility/Transmission Fee |
| | A facility fee is provided to a health care provider at the originating site. |
| | An originating facility fee may only be billed in the event that the originating site is in a healthcare provider’s facility. |
| | When an FQHC or RHC serves as the originating site, the facility fee is paid separately from the center or clinic all-inclusive rate. |
| | The Department does not reimburse a transmission fee. |
| | **Source:** MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4. p. 1, 6, 10. (Apr. 9, 2018). (Accessed Sept. 2018). |
Medicaid Telehealth Reimbursement

| Provider manual indicates coverage of “telehealth services” which is inclusive of store-and-forward, however the manual only discusses interactive telehealth, and remote patient monitoring in detail. Additionally, the manual only discusses the use of the GT modifier (live interactive video), and does not mention the GQ modifier (asynchronous). |
| Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4. (Accessed Sept. 2018). |

| Eligible Services/Speciﬁcations | No reference found. |
| Store-and-Forward | No reference found. |
| Geographic Limits | No reference found. |
| Transmission Fee | No reference found. |

Remote Patient Monitoring

| ME Medicaid provides coverage for telemonitoring services (which may or may not take place in real time) under certain circumstances. Covered telemonitoring services include: |
| Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4.04. p. 4-5. (Accessed Sept. 2018). |

| Home and Community Beneﬁts for the Elderly and for Adults with Disabilities |
| Real time remote support monitoring is covered under Home and Community Beneﬁts for the Elderly and for Adults with Disabilities. Services may include a range of technological options including in-home computers, sensors and video camera linked to a provider that enables 24/7 monitoring. |
Medicaid Telehealth Reimbursement

Remote Patient Monitoring

In order to be eligible for telemonitoring a member must:

- Be eligible for home health services;
- Have a diagnosis of a health condition requiring monitoring of clinical data at a minimum of five times per week, for at least one week;
- Have documentation in the patient’s medical record that the patient is at risk of hospitalization or admission to an emergency room or have continuously received Telemonitoring Services during the past calendar year and have a continuing need for such services, as documented by an annual note from a health care provider;
- Have telemonitoring services included in the Member’s plan of care;
- Reside in a setting suitable to support telemonitoring equipment; and
- Have the physical and cognitive capacity to effectively utilize the telemonitoring equipment or have a caregiver willing and able to assist with the equipment.


Home and Community Benefits for the Elderly and for Adults with Disabilities

Final approval must be obtained from the Department, Office of Aging and Disability Services while considering:

- Number of hospitalizations in the past year;
- Use of emergency room in the past year;
- History of falls in the last six months resulting from injury;
- Member lives alone or is home alone for significant periods of time;
- Service access challenges and reasons for those challenges;
- History of behavior indicating that a member’s cognitive abilities put them at a significant risk of wandering; and
- Other relevant information.


Provider Limitations

In order to be reimbursed for services, Health Care providers:

- Must be enrolled as MaineCare providers in order to be reimbursed for services;
- Be a certified Home Health Agency pursuant to the MaineCare Benefits Manual Ch. II Section 40 (“Home Health Services”);
- The Provider ordering the service must be a Provider with prescribing privileges (physician, nurse practitioner or physician’s assistant);
- Must document that they have had a face-to-face encounter with the member before a physician may certify eligibility for services under the home health benefit. This may be accomplished through interactive telehealth services, but not by telephone or e-mail.

Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4.01. (Accessed Sept. 2018).

Other Restrictions

Department required to adopt regulations that comply with the following:

- May not include any requirement that a patient have a certain number of ER visits or hospitalizations related to the patient’s diagnosis in the criteria for a patient’s eligibility for telemonitoring services;
- Must include qualifying criteria for a patient’s eligibility of telemonitoring services that include documentation in a patient’s medical record that the patient is at risk of hospitalization or admission to an ER;
- Must provide that group therapy for behavioral health or addiction services covered by the MaineCare program may be delivered through telehealth; and
- Must include requirements for individual providers and the facility or organization in which the provider works for providing telehealth and telemonitoring services.

Source: ME Statute Sec. 3173-H.
A health care provider must document that a face-to-face encounter with the member occurred before they are eligible for a home health benefit. This can occur through interactive telehealth services, but not by telephone or e-mail.

**Source:** MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4.03. (Accessed Sept. 2018)

ME established the ME Telehealth and Telemonitoring advisory group to evaluate difficulties related to telehealth and telemonitoring services and make recommendations to the department to improve it statewide.

**Source:** ME Statute Sec. 3173-I.

**Home and Community Benefits for the Elderly and for Adults with Disabilities**

Use of remote monitoring requires sufficient Back Up Plans and the SCA will be responsible for ensuring that the member has at least two adequate back-up plans prior to making a referral for this service.


Telephonic services may be reimbursed if the following conditions are met:

- Interactive telehealth services are unavailable; and
- A telephonic service is medically appropriate for the underlying covered service.

Services may not be delivered through electronic mail.

Interprofessional telephone/internet assessment are among the listed reimbursable procedure codes.

**Source:** MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4. (Accessed Apr. 2018).

For Indian Health Services, a second tier consultation can utilize direct email communications or telephone consultation.


Telephone is also covered for:

- Targeted Case Management Services for purposes of monitoring and follow up activities can take place over the telephone.
- Telephone can be used under the Home and Community Benefits for the Elderly and for Adults with Disabilities for purposes of monitoring.
- Behavioral Health Services for purposes of crisis resolution services when at least one face-to-face contact is made with the member within seven days prior to the first contact related to the crisis resolution service.

Providers must deliver written educational information to patients at their visit. This information should be in a format and manner that the Member is able to understand and include the following:

- Description of the telehealth services and what to expect;
- Explanation that the use of telehealth for this service is voluntary and that the member is able to refuse the telehealth visit at any time without affecting the right to future care or treatment or loss or withdrawal of MaineCare benefit;
- Explanation that MaineCare will pay for transportation to a distant appointment if needed;
- Explanation that the Member will have access to all information resulting from the telehealth service provided by law;
- The dissemination, storage or retention of an identifiable Member image or other information shall comply with federal and state laws and regulations requiring confidentiality;
- Informed of all parties who will be present at the receiving and originating site and have the right to exclude anyone from either site; and
- Member has the right to object to videotaping or other recording of consult.

Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4. (Accessed Sept. 2018).

Member’s record must document consent for RPM.


Healthcare Providers must be licensed or certified in the state of Maine.

Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4.01. (Accessed Sept. 2018).

MaineCare will pay for transportation to a distant appointment if needed.

Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4.06. (Apr. 9, 2018). (Accessed Sept. 2018).

The Department is required to report on the utilization of telehealth and telemonitoring services within the MaineCare program annually beginning in 2018.

The Department is required to conduct educational outreach to providers and MaineCare members on telehealth and telemonitoring.

Source: ME Statute Sec. 3173-H.

Tele-pharmacy is allowed.

Tele-pharmacy is a method of delivering prescriptions dispensed by a pharmacist to a remote site. Pharmacies using tele-pharmacy must follow all applicable State and Federal regulations, including use of staff qualified to deliver prescriptions through tele-pharmacy.

Providers may dispense prescriptions via tele-pharmacy; pre-authorization is required.

### Private Payer Laws

**Definitions**

“Telemedicine, as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. ‘Telemedicine’ does not include the use of audio-only telephone, facsimile machine or e-mail.”

*Source: ME Revised Statutes Annotated. Title 24, Sec. 4316.*

**Requirements**

A health plan may not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would have been covered through an in-person consultation between a covered person and a health care provider. Coverage must be determined in a manner consistent with coverage for services provided through in-person consultation.

*Source: ME Revised Statutes Annotated. Title 24 Sec. 4316.*

**Parity**

A health plan may not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would have been covered through an in-person consultation between a covered person and a health care provider.

*Source: ME Revised Statutes Annotated. Title 24 Sec. 4316.*

Coverage must be determined in a manner consistent with coverage for services provided through in-person consultation.

*Source: ME Revised Statutes Annotated. Title 24 Sec. 4316.*

### Professional Regulator/Health & Safety

**Definitions**

**Board of Licensure in Medicine & Board of Osteopathic Licensure**

“Telemedicine” means the practice of medicine or the rendering of health care services using electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine includes asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology. Telemedicine shall not include the provision of medical services only through an audio-only telephone, e-mail, instant messaging, facsimile transmission, or U.S. mail or other parcel service, or any combination thereof.

*Source: ME Regulation Sec. 02-373-6 & 02-383-6.*
Board of Licensure in Medicine & Board of Osteopathic Licensure

A licensee who uses telemedicine shall ensure the patient provides appropriate informed consent for the health care services provided, including consent for the use of telemedicine, which must be documented in the patient's medical record.

Source: ME Regulation Sec. 02-373-6 & 02-383-6.

Board of Licensure in Medicine & Board of Osteopathic Licensure

Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine in providing health care shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast to an adaptive interactive and responsive online interview, does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by the licensee.

A valid physician-patient relationship may be established between a licensee who uses telemedicine in providing health care and a patient who receives telemedicine services through consultation with another licensee or through a telemedicine encounter if the standard of care does not require an in-person encounter and in accordance with evidence-based standards for practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

Source: ME Regulation Sec. 02-373-6 & 02-383-6.

Adopted the Interstate Medical Licensure Compact.


Member of Nurse Licensure Compact.


A physician who is not licensed in Maine can practice medicine in Maine through interstate telemedicine if they are licensed in the state they are providing telemedicine from, their license is in good standing, the physician does not open an office, meet patients or receive calls in the state and agrees to provide only consultative services as requested by other physicians, APRNs or PAs, and the physician annually registers with the board and pays a fee.

Source: 32 MSRA Sec. 3300-D.

The Board may issue an interstate telemedicine consultation registration to an applicant who:

- Submits an administratively complete application on forms approved by the Board;
- Pays the appropriate licensure application fee;
- Demonstrates that the applicant is a physician and is fully licensed without restriction to practice medicine in the state from which the physician provides telemedicine services;
- Meets the examination requirement;
- Has not had a license to practice medicine revoked or restricted in any state or jurisdiction; and
- Has no cause existing that may be considered grounds for disciplinary action or denial of licensure as provided by law.
A physician registered for the interstate telemedicine consultation shall not:

- Open an office in this State;
- Meet with patients in this State;
- Receive calls in this State from patients; and
- Shall provide only consultative services as requested by a physician, advanced practice registered nurse or physician assistant licensed in this State who retains ultimate authority over the diagnosis, care and treatment of the patient.

Source: ME Regulation Sec. 02-373 Ch. 1, pg 13-14.

Professional regulation with telehealth specific standards

- Board of Licensure in Medicine (Source: ME Regulation Sec. 02-373-6)
- Board of Osteopathic Licensure (Source: ME Regulation 02-383-6)
**Summary**

Maryland Medicaid covers live video telehealth conducted by specific providers and specific originating sites. Although the Medicaid program does not reimburse for store-and-forward, dermatology, ophthalmology and radiology are excluded from the definition of store-and-forward. Maryland Medicaid does reimburse for remote patient monitoring for patients with certain chronic conditions and exhibiting certain risk factors.

**Definitions**

**Telemedicine** means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology:

1. By a health care provider to deliver a health care service that is within the scope of practice of the health care provider at a site other than the site at which the patient is located; and
2. That enables the patient to see and interact with the health care provider at the time the health care service is provided to the patient.

**Source:** MD Health General Code 15-105.2.

"Telehealth means the delivery of medically necessary somatic or behavioral health services to a patient at an originating site by distant site provider, through the use of technology-assisted communication."

**Source:** Code of Maryland Admin. Regs. Sec. 10.09.49.02.

**Reimbursement**

Reimbursement for telehealth is required for services appropriately delivered through telehealth and may not exclude from coverage a health care service solely because it is through telehealth.

The Department may require providers to submit a registration form to include information required for the processing of telehealth claims.

**Source:** MD General Health Code Sec. 15-105.2 & Insurance Code 15-139.

**Managed Care**

MCOs shall provide coverage for medically necessary telemedicine services.

**Source:** Code of Maryland Admin. Regs. Sec. 10.09.67.31.

Maryland Medicaid provides a telehealth program that employs a “hub-and-spoke” model. Communication must be in real time, and the participant must be at an originating site with a telepresenter.


**Mental Health**

The Department shall grant approval to a telemental health provider to be eligible to receive State or federal funds for providing interactive telemental health services.

**Source:** Code of Maryland Admin. Regs. Sec. 10.21.30.03.
Covered Services - Somatic and behavioral health services: Providers must contact the participant’s healthchoice MCO or Beacon Health Option with questions regarding prior authorization requirements for telehealth services.


Medically necessary services are covered by the Maryland Medical Assistance Program as long as they are:

- Distinct from services provided by the originating site provider;
- Able to be delivered using technology-assisted communication; and
- Clinically appropriate to be delivered via telehealth;

Source: Code of Maryland Admin. Regs. Sec. 10.09.49.05.

Services should be billed with the GT modifier.

Source: Code of Maryland Admin. Regs. Sec. 10.09.49.11.

Mental Health Eligible Services:

- Diagnostic interview
- Individual therapy
- Family therapy
- Group therapy for the individual
- Outpatient evaluation and management
- Outpatient office consultation
- Initial inpatient consultation
- Emergency department services


Recently Approved Legislation (Now Effective – Expires in two years at the end of September 30, 2020)

If the Department specifies by regulation the types of health care providers eligible to receive reimbursement, the types of health care providers shall include:

- Primary care providers; and
- Psychiatrists who are providing assertive community treatment or mobile treatment services to program recipients located in a home or community-based setting.

Health services provided by a psychiatrist described above is equivalent to the same health care service when provided through in-person consultation.


Eligible distant site provider:

- Nurse midwife
- Nurse practitioner
- Psychiatric nurse practitioner
- Physician;
- A physician assistant; or
- A provider fluent in American Sign Language providing telehealth services to a deaf or hard of hearing participant;

The following sites can register as distant site providers:

- A community-based substance use disorder provider;
- An opioid treatment program;
- An outpatient mental health center; or
- A Federally Qualified Health Center.
Medicaid Telehealth Reimbursement

Telehealth providers must be enrolled in the Maryland Medical Assistance Program and register as an originating or distant site via an online form before rendering telehealth services. Additionally, providers billing for behavioral health services must register with the Department’s administrative service organization (ASO) before rendering behavioral health services.


Mental Health

Eligible Providers:

- Outpatient mental health centers
- Telemental health (TMH) providers who are individual psychiatrists.

Telemental health providers may be private practice, part of a hospital, academic, health or mental health care system. Public Mental Health System (PMHS) approved community-based providers or individual practitioners may engage in agreements with TMH providers for services. Fee-for-service reimbursement shall be at an enhanced rate, as stipulated by the Department, provided all applicable provisions of this chapter are met and funds are available.


Eligible originating sites:

- College or university student health or counseling office
- Community-based substance use disorder provider
- Deaf or hard of hearing participant’s home or any other secure location approved by the participant and provider
- Elementary, middle, high or technical school with a supported nursing, counseling or medical office
- Local health department
- FQHC
- Hospital, including emergency department
- Nursing facility
- Private office
- Opioid treatment program
- Outpatient mental health center
- Renal dialysis center; or
- Residential crisis services site

Telehealth providers must be enrolled in the Maryland Medical Assistance Program and register as an originating or distant site via an online form before rendering telehealth services. Additionally, providers billing for behavioral health services must register with the Department’s administrative service organization (ASO) before rendering behavioral health services.


SBHC with FQHC or local health department sponsoring entities may register as originating sites and bill the telehealth transmission fee code after the SBHC receives approval from MSDE enrolls as a Medicaid provider.

### Medicaid Telehealth Reimbursement

#### Mental Health

**Eligible Originating Sites:**

- County government offices appropriate for private clinical evaluation services;
- Critical Access Hospital;
- Federally Qualified Health Center;
- Hospital;
- Outpatient mental health center;
- Physician’s office;
- Rural Health Clinic;
- Elementary, middle, high, or technical school with a supported nursing, counseling or medical office; or
- College or university student health or counseling office.

*Source: Code of Maryland Admin. Regs. Sec. 10.21.30.05.*

#### Geographic Limits

**Mental Health**

To be eligible a beneficiary must reside in one of the designated rural geographic areas or whose situation makes person-to-person psychiatric services unavailable.

*Source: Code of Maryland Admin. Regs. Sec. 10.21.30.05.*

#### Facility/Transmission Fee

Originating sites may bill for a transmission fee code Q3014.


Originating sites are eligible for a transmission fee. Fee set in COMAR 10.09.07D; or by the Health Services Cost Review Commission for sites located in regulated space.

Transmission fees paid to the originating site may be used to pay for: Line or per minute usage charges or both; and any additional programmatic, administrative, clinical or contingency support at the originating site.

*Source: Code of Maryland Admin. Regs. Sec. 10.09.49.11.*

#### Store-and-Forward

**Policy**

The department may provide reimbursement for services delivered through store-and-forward technology.

*Source: Health General Code 15-105.2.*

Maryland Medicaid does not cover store-and-forward, however dermatology, ophthalmology and radiology are covered under Physician services of COMAR.


MD Medicaid does not cover store-and-forward. However, dermatology, ophthalmology and radiology are excluded from definition of store-and-forward. They do reimburse for these services according to COMAR 10.09.02.07.

*Source: Code of Maryland Admin. Regs. Sec. 10.09.49.10.*
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Store-and-forward</th>
<th>Geographic Limits</th>
<th>Transmission费</th>
<th>No reference found.</th>
<th>No reference found.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Remote Patient Monitoring</strong></td>
<td><strong>Policy</strong></td>
<td><strong>Conditions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid recipients diagnosed with one of the following conditions qualify:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Chronic Obstructive Pulmonary Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Congestive Heart Failure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Diabetes (Type 1 or 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The department may provide reimbursement for services delivered through remote patient monitoring technology.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Source:</strong> Health General Code 15-105.2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD Medicaid reimburses for remote patient monitoring for certain chronic conditions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reimbursement for home health monitoring services under telehealth manual.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible Providers:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Home Health Agencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Clinics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Federally Qualified Health Centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Managed Care Organizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Health Professionals (Physicians, Nurses, Physician Assistants)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Medicaid Telehealth Reimbursement

#### Remote Patient Monitoring
- Preauthorization required.
- RPM reimbursement rate covers equipment installation, participant education for using the equipment, and daily monitoring of the information transmitted for abnormal data measurements.
- Reimbursement does not include RPM equipment, upgrades to RPM equipment or internet service for participants.


#### Other Restrictions

- Email / Phone / Fax
  - No reimbursement for email.
  - No reimbursement for telephone.
  - No reimbursement for FAX.
  - No reimbursement for email, phone or telephone conversations between providers.


#### Consent
- The originating site must obtain consent. If the participant is unable to provide consent, the medical record must contain in writing an explanation as to why the participant was unable to consent to telehealth services.


- Consent is required unless there is an emergency.

*Source: Code of Maryland Admin. Regs. Sec. 10.09.49.06*

#### Mental Health
- An individual must voluntarily consent to telemental health services, which must be documented in the individual’s medical record.

*Source: Code of Maryland Admin. Regs. Sec. 10.21.30.05*

#### Out of State Providers
- No reference found.
Medicaid Telehealth Reimbursement

Technology requirements for providers:

- A camera with specific resolution, focus, and zoom capabilities
- Have display monitor sufficient in size
- Bandwidth speed and image resolution sufficient to provide quality video
- Audio equipment that ensures clear communication, unless engaging with a participant who is deaf or hard of hearing
- Creates audio transmission with less than 300 millisecond delay
- Secure and HIPAA compliant telehealth communication

Must ensure HIPAA compliance.

Provider manual outlines various telehealth provider scenarios.


Providers of health care services delivered through telehealth must use video and audio transmission with less than a 300 millisecond delay. Other minimum technology requirements apply.

Source: Code of Maryland Admin. Regs. Sec. 10.09.49.08.

Providers may not store at originating or distant site video images or audio portion of telemedicine services for future use.

Source: Code of Maryland Admin. Regs. Sec. 10.09.49.09.

Private Payer Laws

Definitions

Telehealth means, as it relates to the delivery of health care services, the use of interactive audio, video or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a location other than the location of the patient. Telehealth does not include audio only telephone between a health care provider and a patient; an electronic mail message between a health care provider and a patient; or a facsimile transmission between a healthcare provider and patient.

Source: MD Insurance Code 15-139.

Requirements

Insurers must provide coverage under a health insurance policy for health care services appropriately delivered through telehealth and may not exclude coverage solely because it is provided through telehealth and not in-person. The health care services appropriately provided through telehealth must include counseling for substance use disorder.

A health insurer can undertake utilization review, including preauthorization to determine the appropriateness of any health care service whether delivered in-person or through telehealth if the appropriateness is determined in the same manner.

Source: MD Insurance Code Annotated Sec. 15-139.

Parity

Service Parity

Insurers must reimburse a health care provider for the diagnosis, consultation and treatment of an insured patient that can be appropriately provided through telehealth.

Source: MD Insurance Code Annotated Sec. 15-139.
<table>
<thead>
<tr>
<th>Private Payer Laws</th>
<th>Parity</th>
<th>Payment Parity</th>
</tr>
</thead>
</table>
| **Audiologists, Hearing Aid Dispensers and Speech Language Pathologists:**  
“Telehealth means the use of telecommunications and information technologies for the exchange of information from one site to another, for the provision of health care to an individual from a provider through hardwire or Internet connection.”  
**Source:** MD Health Occupations Annotated Sec. 2-101. |
| **Board of Physicians:**  
“Telemedicine means the practice of medicine from a distance in which intervention and treatment decisions and recommendations are based on clinical data, documents, and information transmitted through telecommunications systems.”  
**Source:** Code of Maryland Admin. Regs. Sec. 10.32.05.02. |
| **Perinatal and Neonatal Referral Center Standards:**  
“Telemedicine” means the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located, in compliance with COMAR 10.32.05.and including at least two forms of communication.  
**Source:** MD COMAR Sec. 30.08.12.01. |
| **Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech Language Pathologists**  
Telehealth providers must inform patients and consultants of the following:  
- The inability to have direct, physical contact with the patient is a primary difference between telehealth and direct in-person service delivery;  
- The knowledge, experiences, and qualifications of the consultant providing data and information to the provider of the telehealth services need not be completely known to and understood by the provider;  
- The quality of transmitted data may affect the quality of services provided by the provider;  
- That changes in the environment and test conditions could be impossible to make during delivery of telehealth services.  
Telehealth services may not be provided by correspondence only.  
**Source:** Code of MD Reg., 10.41.06.04. |
| Except when providing interpretive services, the physician must obtain and document patient consent.  
**Source:** Code of Maryland Admin. Regs. Sec. 10.32.05.06. |
A physician-patient relationship can be established through real time auditory communications or real time visual and auditory communications.

**Source:** Code of Maryland Admin. Regs. Sec. 10.32.05.05.

Member of the Interstate Medical Licensure Compact.

**Source:** Senate Bill 234 (2018).

Member of Nurse Licensure Compact.


MD has exceptions to its MD-only licensed physicians for physicians practicing in the adjoining states of Delaware, Virginia, West Virginia, and Pennsylvania.

**Source:** MD Health Occupations Code Annotated Sec. 14-302.

A physician providing services through telemedicine must have a Maryland license if they are located in Maryland, or if the patient is in Maryland.

**Source:** Code of Maryland Admin. Regs. Sec. 10.32.05.03.

Specific standards apply for physicians utilizing a website to communicate with patients.

**Source:** Code of Maryland Admin. Regs. Sec. 10.32.05.02 & 10.32.02.

**Professional Telehealth-Specific Regulations**

- Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech Language Pathologists (Source: COMAR 10.41.06).
- Board of Physicians (Source: COMAR 10.32.05)
**Medicaid Program:** MassHealth

**Program Administrator:** MA Dept. of Health and Human Services

**Regional Telehealth Resource Center:** Northeast Regional Telehealth Resource Center

**Covers the States of:** Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island & Vermont

[www.netrc.org](http://www.netrc.org)

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Massachusetts Medicaid (MassHealth) makes no reference to reimbursement of telehealth or telemedicine within their policies. There is, however a 2014 budget bill that allocated funds for the reimbursement of remote patient monitoring telehealth. CCHP has found no further details regarding this. It should be noted that Massachusetts is a managed care state, and that some individual Medicaid managed care plans may reimburse for telehealth delivered services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Live Video</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Eligible Services / Specialties</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td>Eligible Providers</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Live Video</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Store-and-Forward</td>
<td></td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---</td>
</tr>
<tr>
<td><strong>Store-and-Forward</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Geographic Limits</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Transmission Fee</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Policy</strong></td>
<td>In the FY 2014 State Budget, MA appropriates funds for the reimbursement of telehealth remote patient monitoring provided by home health agencies as a service to clients reimbursable through Medicaid, as long as it is for short term reimbursement.</td>
</tr>
<tr>
<td><strong>Conditions</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Provider Limitations</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Other Restrictions</strong></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
Medicaid Telehealth Reimbursement

Consent

Out of State Providers

Miscellaneous

Private Payer Laws

Definitions

Requirements

“Telemedicine as it pertains to the delivery of health care services, shall mean the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. ‘Telemedicine’ shall not include the use of audio-only telephone, facsimile machine or e-mail.”

Source: Annotated Laws of MA. Part I, Title XXII, Ch. 175, Sec. 47BB.

Private payers may provide coverage of telemedicine services, subject to contract terms and conditions, and must be consistent with coverage for health care services provided through in-person consultations.

Source: Annotated Laws of MA. Part I, Title XXII, Ch. 175, Sec. 47BB.
<table>
<thead>
<tr>
<th>Private Payer Laws</th>
<th>Service Parity</th>
<th>Coverage shall be consistent with coverage for health care services provided through in-person consultation.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Source:</strong> Annotated Laws of MA. Part I, Title XXII, Ch. 175, Sec. 47BB.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Regulation/Health &amp; Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Consent</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Online Prescribing</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Cross-State Licensing</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Private payers may provide coverage of telemedicine services.

**Source:** Annotated Laws of MA. Part I, Title XXII, Ch. 175, Sec. 47BB.

Prior to any e-prescribing, there must be a physician-patient relationship that conforms to certain minimum norms and standards of care, which includes taking a medical history and conducting an appropriate exam.

No reference found.
Michigan Medicaid reimburses for live video telemedicine for certain healthcare professionals, for patients located at certain originating sites for specific services. There is no reimbursement for store-and-forward or remote patient monitoring.

“Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location.”


**Assertive Community Treatment Program**
Telepractice is the use of telecommunications and information technologies for the provision of psychiatric services to ACT consumers and is subject to the same service provisions as psychiatric services provided in-person.


**Behavioral Health Treatment Services (BHT)**
Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services (e.g., access or travel to needed medical services may be prohibitive).


**Medication Therapy Management**
Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services. Telepractice must be obtained through real-time interactions between the beneficiary’s physical location (origin site) and the pharmacist provider’s physical location (distant site).


**Speech-Language and Audiology Services; Medication Therapy Management**
“Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of speech, language and hearing services. Telepractice must be obtained through real-time interaction between the patient’s physical location (patient site) and the provider’s physical location (provider site).”

Medicaid Telehealth Reimbursement

Live video telemedicine is reimbursed, and should primarily be used when travel is prohibitive for the beneficiary or there is an imminent health risk justifying immediate medical need for services. Where face-to-face visits are required, telemedicine services may be used in addition to the required face-to-face visit, but cannot be used as a substitute.


**Assertive Community Treatment Program**

All telepractice interactions shall occur through real-time interactions between the ACT consumer and the physician/nurse practitioner from their respective physical location. Psychiatric services are the only ACT services that are approved to be provided in this manner.


Michigan Medicaid reimburses for the following services categories via live video:

- Inpatient Consults;
- Office or other outpatient consults
- Office or other outpatient services
- Psychiatric diagnostic procedures
- Subsequent hospital care
- Training services, diabetes
- End stage renal disease (ESRD) related services. However, there must be at least one in-person visit per month, by a physician, nurse practitioner, or physician’s assistant, to examine the vascular site for ESRD services.
- Behavior change intervention, individual
- Behavior health and/or substance use disorder treatment
- Education service, telehealth
- Nursing facility subsequent care

Procedure codes and modifier information is contained in the MDHHS Telemedicine Services Database.


**Speech-Language and Audiology Services**

Speech, language and hearing services may be reimbursed. Requires an annual referral from a physician.


**Assertive Community Treatment Program**

The telepractice modifier, 95, must be used in conjunction with ACT encounter reporting code H0039 when telepractice is used.


**Telepractice for BHT Services**

Telepractice services must be prior authorized. Telepractice must be obtained through real-time interaction between the child’s physical location (patient site) and the provider’s physical location (provider site). Telepractice services are provided to patients through hardwire or internet connection. It is the expectation that providers, facilitators, and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients, and services provided via telepractice are provided as part of an array of comprehensive services that include in-person visits and assessments with the primary supervising BHT provider. Qualified providers of behavioral health services are able to arrange telepractice services for the purposes of teaching the parents/guardians to provide individualized interventions to their child and to engage in behavioral health clinical observation and direction (i.e. increase oversight of the provision of services to the beneficiary to support the outcomes of the behavioral plan of care developed by the primary supervising BHT provider).

Physicians and practitioners are eligible to be distant site providers.


**Telepractice for BHT Services**

Qualified providers include:

- Board certified behavior analysts
- Board certified assistant behavior analysts
- Licensed psychologists
- Limited licensed psychologists
- Qualified behavioral health professionals

Occupational, physical and speech therapists are not included in this policy.

A facilitator trained in telepractice technology must be physically present with the patient.


**Medication Therapy Management (MTM)**

In the event that the beneficiary is unable to physically access a face-to-face care setting, an eligible pharmacist may provide MTM services via telepractice. Services must be provided through hardwire or internet connection.


Prepaid Inpatient Health Plans/Community Mental Health (PIHP/CMH) can be either originating or distant sites.


**Speech-Language and Audiology Services**

Eligible providers:

- Licensed speech-language pathologist
- Licensed Audiologist in Michigan
- Speech language pathologist and/or audiology candidate under the direction of a qualified SLP or audiologist
- A limited licensed speech language pathologist under the direction of a fully licensed SLP or audiologist


**Speech-Language and Audiology Services**

The patient site may be located within the school, at the patient’s home or any other established site deemed appropriate by the provider.


Eligible originating sites:

- County mental health clinics or publicly funded mental health facilities;
- Federally Qualified Health Centers;
- Hospitals (inpatient, outpatient, or Critical Access Hospitals);
- Physician or other providers’ offices, including medical clinics;
- Hospital-based or CAH-based Renal Dialysis Centers;
- Rural Health Clinics;
- Skilled nursing facilities;
- Tribal Health Centers

Medicaid Telehealth Reimbursement

**Eligible Sites**

Prepaid Inpatient Health Plans/Community Mental Health (PIHP/CMH) can be either originating or distant sites.


**Behavioral Health Therapy**

Eligible patient site:

- Center
- Clinic
- Patient’s home
- Any other established site deemed appropriate by the provider

Room must be free of distractions. A trained facilitator must be present at the patient site.


**Facility/Transmission Fee**

Originating site may bill for a facility fee. MDHHS will reimburse the originating site provider the lesser of charge or the current Medicaid fee screen.


**Geographic Limits**

No reference found.

**Policy**

Telecommunication systems using store-and-forward technology are not included in MI Medicaid’s telemedicine policy.

*Source: Dept. of Community Health, Medicaid Provider Manual, p. 1668 (Accessed Sept. 2018).*

**Store-and-Forward**

No reference found.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Store-and-Forward</th>
<th>No reference found.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Geographic Limits</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Transmission Fee</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Policy</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Conditions</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Provider Limitations</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Other Restrictions</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
Medicaid Telehealth Reimbursement

Out of State Providers

Telemedicine services must 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.


Behavioral Health Therapy

Must be fully licensed in MI or be a practitioner who holds a limited license and is under the direction of a licensed psychologist.


Miscellaneous

No reimbursement for remote access for surgical procedures, and use of robotics.


Definitions

Telemedicine means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine, 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.

Source: MI Compiled Law Svcs. Sec. 500.3476.

Private Payer Laws

Requirements

Insurers (including dental care corporations) 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 insurer. 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 contract.

Source: MI Compiled Law Services Sec. 500.3476.
<table>
<thead>
<tr>
<th>Private Payer Laws</th>
<th>Service Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parity</strong></td>
<td>Insurers must cover services appropriately provided through telemedicine, as determined by the insurer.</td>
</tr>
<tr>
<td></td>
<td>Source: Mi Compiled Law Services Sec. 500.3476.</td>
</tr>
<tr>
<td><strong>Payment Parity</strong></td>
<td>No explicit payment parity.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consent</strong></td>
<td>Consent must directly or indirectly be obtained by a health care professional utilizing telehealth.</td>
</tr>
<tr>
<td>Source: Mi Compiled Laws Sec. 333.16284.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Regulation/Health &amp; Safety</th>
<th>Online Prescribing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consent</strong></td>
<td>Suppliers must have an existing physician-patient relationship.</td>
</tr>
<tr>
<td>Source: Mi Compiled Laws Sec. 333.17751.</td>
<td></td>
</tr>
<tr>
<td><strong>Online Prescribing</strong></td>
<td>Controlled substances cannot be prescribed unless the prescribing is in a bona fide prescriber-patient relationship with the patient. A “bona fide prescriber-patient relationship” means a treatment or counseling relationship between a prescriber and a patient in which both of the following are present:</td>
</tr>
<tr>
<td>• The prescriber has reviewed the patient’s relevant medical or clinical records and completed a full assessment of the patient’s medical history and current medical condition, including a relevant medical evaluation of the patient conducted in-person or through telehealth.</td>
<td></td>
</tr>
<tr>
<td>• The prescriber has created and maintained records of the patient’s condition in accordance with medically accepted standards.</td>
<td></td>
</tr>
<tr>
<td>Source: Mi Compiled Laws Sec. 333.7303a.</td>
<td></td>
</tr>
</tbody>
</table>
### Online Prescribing

A health professional providing telehealth service to a patient may prescribe the patient a drug if both the following are met:

- The health professional is a prescriber who is acting within the scope of his or her practice; and
- If the health professional is prescribing a controlled substance, the health professional must meet the requirements of this act applicable to that health professional for prescribing a controlled substance.

The health professional must also provide a referral for health care services that are geographically accessible to the patient, if medically necessary. They also must make himself or herself (or a delegated health professional) available for follow-up care or refer the patient to another health professional for follow-up care.

*Source: Mi Compiled Laws, Sec. 16285.*

### Cross-State Licensing

No reference found.

### Miscellaneous

The Department is required to study the use of telemedicine to perform competency examinations by forensic psychiatrists.

*Source: SB 270 (2017).*
**Minnesota**

**Medicaid Program:** Medical Assistance  
**Program Administrator:** MN Dept. of Human Services  
**Regional Telehealth Resource Center:** Great Plains Telehealth Resource and Assistance Center  
**Covers the States of:** Iowa, Minnesota, Nebraska, North Dakota, South Dakota, & Wisconsin  
[www.gptrac.org](http://www.gptrac.org)

<table>
<thead>
<tr>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota Medicaid provides reimbursement for live video and store-and-forward through their Medical Assistance program for certain providers when patients are located at specific originating sites. Many of their individual programs have their own unique requirements for telemedicine reimbursement. Additionally, tele-home-care (remote monitoring) is reimbursed with prior authorization under Home Care Services and the Elderly Waiver (EW) and Alternative Care (AC) program, but specific reimbursement criteria is not listed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
</table>
| “Telemedicine is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient’s health care.”  

Source: MN Statute 256B.0625.Subdivision 3b(d).  

“Telemedicine is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site.”  


**Chemical Dependency Treatment**  
“Telemedicine” means the delivery of a substance use disorder treatment service while the client is at an originating site and the licensed health care provider is at a distant site as specified in section 254B.05, subdivision 5, paragraph (f).  

Source: MN Statute Sec. 245G.01.
Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service was delivered in-person. Coverage is limited to three telemedicine services per week per enrollee.

Source: MN Statute Sec. 256B.0625, Subdivision 3b(d).

Minnesota’s Medical Assistance program reimburses live video for fee-for-service programs.

To be eligible for reimbursement, providers must self-attest that they meet the conditions of the MHCP telemedicine policy by completing the Provider Assurance Statement for Telemedicine form.


Examples of eligible services:

- Consultations
- Telehealth consults: emergency department or initial inpatient care
- Subsequent hospital care services with the limitation of one telemedicine visit every 30 days per eligible provider
- Subsequent nursing facility care services with the limitation of one telemedicine visit every 30 days
- End-stage renal disease services
- Individual and group medical nutrition therapy
- Individual and group diabetes self-management training with a minimum of one hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training
- Smoking cessation
- Alcohol and substance abuse (other than tobacco) structured assessment and intervention services

Two-way interactive video consultation may be billed when no physician is in the ER and the nursing staff is caring for the patient at the originating site. The ER physician bills the ER CPT codes with place of service 02.

Telemedicine consults are limited to three per calendar week per patient. Payment is not available for sending materials to a recipient, other provider or facility.

Non-covered services:

- Electronic connections that are not conducted over a secure encrypted website as specified by the Health Insurance Portability & Accountability Act of 1996 Privacy & Security rules (e.g., Skype)
- Prescription renewals
- Scheduling a test or appointment
- Clarification of issues from a previous visit
- Reporting test results
- Non-clinical communication
- Communication via telephone, email or facsimile
- Day treatment
- Partial hospitalization programs
- Residential treatment services
- Case management face-to-face contact

Mental health telemedicine - Mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via two-way interactive video. Use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the service. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Source: MN Statute Sec. 256B.0625, Subd. 46.

Assertive Community Treatment and Intensive Residential Treatment Services

Physician services, whether billed separately or included in the rate, may be delivered by telemedicine when it is within the scope practice and the provider is a member of the intensive residential treatment services treatment team.


Individualized Education Program (IEP)

Telemedicine coverage applies to a child or youth who is MA eligible, has an IEP and the service provided is identified in the IEP. Whether the originating site is a home or school must be documented in the child’s health record. Limited to three visits per week per child or youth.

To be eligible for reimbursement, the school or school district must self-attest that the telemedicine services provided by the professional provider either employed by or contracted by the school meet all of the conditions of the MHCP telemedicine policy by completing the Provider Assurance Statement for Telemedicine (DHS-6806) (PDF).

Non-Covered Services

- Services that are less effective than if provided in-person, face-to-face
- Supervision evaluations or visits
- Evaluations or assessments
- Personal care assistants
- Nursing services
- Transportation services
- Electronic connections that are conducted over a website that is not secure and encrypted as specified by the Health Insurance Portability & Accountability Act of 1996 Privacy & Security rules (for example, Skype)
- Prescription renewals
- Scheduling a test or appointment
- Clarification of issues from a previous visit
- Reporting test results
- Non-clinical communication
- Communication via telephone, email or fax

Use GT modifier and 02 place of service code. See IEP manual for specific documentation and billing requirements.


Mental Health Services

Providers authorized to provide mental health services may conduct the same services via telemedicine, except:

- Day treatment
- Partial hospitalization programs
- Residential treatment services
- Case management, face-to-face contact

Providers should bill with the GT modifier.

Alcohol and Drug Abuse Services
Non-covered Services

• Telem medicine for alcohol and drug abuse services

However, telemedicine guidance from MN on Alcohol and Drug Abuse Services released on Oct. 19, 2017 indicates that they will provide reimbursement when it is medically appropriate and recipient has consented to using telemedicine to receive services.


Dental
Teledentistry services through live video and store-and-forward are allowed. Coverage is limited to children, pregnant women, and limited adult benefits. See list of codes, documentation and billing requirements in provider manual. A provider must self-attest to meet all the conditions of the MHCP telemedicine policy by completing the Provider Assurance Statement for telemedicine.

Noncovered Services:

• Electronic connections that are not conducted over a secure encrypted website as specified by the Health Insurance Portability & Accountability Act of 1996 Privacy & Security rules (for example, Skype)
• Prescription renewals
• Scheduling appointment
• Clarification of issues from a previous visit
• Reporting diagnostic results
• Non-clinical communication
• Communication via telephone, email or fax


Early Intensive Developmental and Behavioral Intervention (EIDBI) EIDBI Services
Telemedicine is an option for Early Intensive Developmental and Behavioral Intervention (EIDBI) EIDBI services. Either the person or his/her family must be present via two-way interactive video while the provider delivers EIDBI telemedicine services. Use 02 place of service code. Coverage is limited to three telemedicine services per recipient per calendar week.

Eligible services include:

• Comprehensive multi-disciplinary evaluation
• Coordinated care conference
• Family/caregiver training and counseling
• Intervention observation and direction

See EIDBI Benefits grid for more information.

Rehabilitation Services
MHCP allows payment for some rehabilitation services through telemedicine. Physical and occupational therapists, speech-language pathologists and audiologists may use telemedicine to deliver certain covered rehabilitation therapy services that they can appropriately deliver via telemedicine. Service delivered by this method must meet all other rehabilitation therapy service requirements and providers must adhere to the same standards and ethics as they would if the service was provided face-to-face. Must use GT or GQ modifiers. Providers must self-attest that they meet all of the conditions of MHCP telemedicine policy by completing the “Provider Assurance Statement for Telemedicine”.

Limited to three sessions per week per recipient. Payment not available for sending materials to a recipient, other providers or other facilities.

Noncovered services:
- Electronic connections that are not conducted over a secure encrypted website as specified by HIPAA
- Scheduling a test or appointment
- Clarification of issues from a previous visit
- Reporting test results
- Non-clinical communication
- Communication via telephone, email or fax


Medication Therapy Management Services (MTMS)
Under certain circumstances MTMS can be delivered via interactive video. See section on “eligible sites” for more information. To be eligible providers must submit a provider assurance statement, use equipment compliant with HIPAA (see manual for details) and use the GT modifier and 02 POS code.


Providers must use the new place of service code 02 beginning Nov. 1, 2017.

Eligible providers:
- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Clinical nurse specialist
- Registered dietitian or nutrition professional
- Dentist, dental hygienist, dental therapist, advanced dental therapist
- Mental health professional, when following requirements and service limitations
- Pharmacist
- Certified genetic counselor
- Podiatrist
- Speech therapist
- Therapist
- Occupational therapist
- Audiologist
- Public health nursing organizations

Individualized Education Program (IEP)
Eligible providers include the following:

- Charter schools
- Education districts
- Intermediate districts
- Public school districts
- Tribal schools (schools that receive funding from the Bureau of Indian Affairs-BIA)
- Service cooperatives
- Special education cooperatives
- State academies


Early Intensive Developmental and Behavioral Intervention (EIDBI)
EIDBI services
Eligible Providers:

- Physician
- Nurse practitioner
- Clinical psychologist
- Clinical social worker
- Speech therapist
- Physical therapist
- Occupational therapist.

Mental health practitioners working under the supervision of a mental health professional are also eligible. A comprehensive multi-disciplinary evaluation provider, qualified supervising professional, (Level I or Level II) EIDBI provider may apply to provide EIDBI services via telemedicine if they meet the qualifications and complete the Telemedicine Assurance Statement.


Mental Health Services
All providers eligible to deliver mental health services may deliver the same services via telemedicine. See manual for specific requirements a provider must follow when delivering services via telemedicine except the following:

- Day treatment
- Partial hospitalization programs
- Residential treatment services
- Case Management, face-to-face contact


Alcohol and Drug Abuse Services
All providers eligible to deliver the same services they are authorized to provide via telemedicine as long as they self-attest to meeting all of the conditions of the MHCP telemedicine policy by completing the Provider Assurance Statement for Telemedicine. Individual, non-residential treatment is the only substance use disorder service currently reimbursed via telemedicine.

Noncovered services include:

- Electronic connections that are not conducted over a secure encrypted web site as specified by the Health Insurance Portability & Accountability Act of 1996 Privacy & Security rules (e.g. Skype)
- Prescription renewals
- Scheduling a test or appointment
- Reporting test results
- Non-clinical communication
- Communication via telephone, email or facsimile
Medicaid Telehealth Reimbursement

Limited to three telemedicine services per week per recipient. Payment is not available to providers for sending materials. See manual for documentation requirements. Use the GT modifier.


Rehabilitation Services

Eligible providers:

• Speech-language pathologists
• Physical therapists
• Physical therapist assistants
• Occupational therapists
• Occupational therapy assistants
• Audiologists

Physical therapist assistants and occupational therapy assistants providing services via telemedicine must follow the same supervision policy as indicated in “Rehabilitation Service Practitioners”. No distant site limitations beyond provider types. Providers must self-attest that they meet all of the conditions of MHCP telemedicine policy by completing the “Provider Assurance Statement for Telemedicine”. See manual for documentation requirements.


Authorized originating sites include:

• Office of physician or practitioner
• Hospital (inpatient or outpatient)
• Critical access hospital (CAH)
• Rural health clinic (RHC) and Federally Qualified Health Center (FQHC)
• Hospital-based or CAH-based renal dialysis center (including satellites)
• Skilled nursing facility (SNF)
• End-stage renal disease (ESRD) facilities
• Community mental health center
• Dental clinic
• Residential facilities, such as a group home and assisted living, shelter or group housing
• Home (a licensed or certified health care provider may need to be present to facilitate the delivery of telemedicine services provided in a private home)
• School
• Correctional facility-based office


Individualized Education Program (IEP)

Eligible originating sites, the location of the child or youth at the time the service is provided. Document in the child’s health record:

• Home
• School

Medicaid Telehealth Reimbursement

**Medication Therapy Management Services (MTMS)**
Qualified members who must travel more than twenty miles for enrolled MHCP MTMS provider may have the services delivered via interactive video to an ambulatory care site in which there is no enrolled MTMS provider in the local trade area. Services must meet the following criteria:

- Both the patient site and the pharmacist site must be located in a pharmacy, clinic, hospital or other ambulatory care site;
- The origination site must meet the MTMS privacy and space requirements except that the space would need to seat only two people;
- Qualified members may have the service delivered via interactive video to their residence if the service is performed during a covered home care visit;
- The pharmacist provider’s site must be located in a pharmacy, clinic, hospital or other ambulatory care site.

See manual for privacy, equipment and reimbursement requirements.


**Alcohol and Drug Abuse Services**
Eligible originating sites:

- Substance abuse disorder treatment facility (residential or outpatient)
- Office of physician or practitioner
- Hospital (inpatient or outpatient)
- Withdrawal management facility
- Drug court office
- Correctional facility-based office (including jails)
- School
- Community mental health center (CCBHC)
- Residential facility such as a group home and assisted living
- Home (a licensed or certified health care provider may need to be present to facilitate the delivery of telemedicine services provided in a private home)


**Dental**
Eligible Originating Sites:

- Health care facility
- Long-term care facility
- Public health agency or institution
- Public or private school authority
- Private non-profit or charitable organizations
- Social services agency or program
- Residential setting in the presence of licensed healthcare providers

Affiliate practice or originator within Minnesota Board of Dentistry defined scope of practice must be present at originating site:

- Dentist
- Advanced dental therapists
- Dental therapists
- Dental hygienists
- Licensed dental assistants
- Other licensed health care professionals

### Medicaid Telehealth Reimbursement

**Rehabilitation Services**

Eligible originating sites:

- Office of physician or practitioner
- Hospital (inpatient or outpatient)
- Critical access hospital (CAH)
- Rural health clinic (RHC) and Federally Qualified Health Center (FQHC)
- Hospital-based or CAH-based renal dialysis center (including satellites)
- Skilled nursing facility (SNF)
- End-stage renal disease (ESRD) facilities
- Community mental health center
- Dental clinic
- Residential facilities, such as a group home and assisted living
- Home (a licensed or certified health care provider may need to be present to facilitate the delivery of telemedicine services provided in a private home)
- School


### Geographic Limits

**Medication Therapy Management Services (MTMS)**

Qualified members who must travel more than twenty miles for enrolled MHCP MTMS provider may have the services delivered via interactive video to an ambulatory care site in which there is no enrolled MTMS provider in the local trade area.


### Facility/Transmission Fee

**Mental Health**

**Early Intensive Developmental and Behavioral Intervention (EIDBI)**

EIDBI Services

MHCP does not reimburse for connection charges or origination, set-up or site fees.


### Store-and-Forward

**Policy**

Telemedicine may be provided through store-and-forward technology to provide or support health care delivery.

*Source: MN Statute Sec. 256B.0625.*

Minnesota’s Medical Assistance program reimburses for services delivered through store-and-forward technology. Medical information may include, but is not limited to video clips, still images, x-rays, MRIs, EKGs, Laboratory results, audio clips and text. Payment will be made for only one reading or interpretation of diagnostic tests. Store-and-forward substitutes for an interactive encounter with the patient present, although the patient is not present in real-time.

Providers must use the new place of service code 02 beginning Nov. 1, 2017. Eligible providers:

- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Clinical nurse specialist
- Registered dietitian or nutrition professional
- Dentist, dental hygienist, dental therapist, advanced dental therapist
- Mental health professional, when following requirements and service limitations
- Pharmacist
- Certified genetic counselor
- Podiatrist
- Speech therapist
- Therapist
- Occupational therapist
- Audiologist
- Public health nursing organizations


See Live Video Eligible Services section for examples of eligible telemedicine services as well as noncovered services.

Dental
Teledentistry services through store-and-forward is allowed. Coverage is limited to children, pregnant women, and limited adult benefits. See list of codes, documentation and billing requirements in provider manual. A provider must self-attest to meet all the conditions of the MHCP telemedicine policy by completing the Provider Assurance Statement for telemedicine.

Noncovered Services:

- Electronic connections that are not conducted over a secure encrypted website as specified by the Health Insurance Portability & Accountability Act of 1996 Privacy & Security rules (for example, Skype)
- Prescription renewals
- Scheduling appointment
- Clarification of issues from a previous visit
- Reporting diagnostic results
- Non-clinical communication
- Communication via telephone, email or fax


Rehabilitation Services
MHCP allows payment for some rehabilitation services through telemedicine. Physical and occupational therapists, speech-language pathologists and audiologists may use telemedicine to deliver certain covered rehabilitation therapy services that they can appropriately deliver via telemedicine. Service delivered by this method must meet all other rehabilitation therapy service requirements and providers must adhere to the same standards and ethics as they would if the service was provided face-to-face. Must use GQ modifier for store-and-forward. Providers must self-attest that they meet all of the conditions of MHCP telemedicine policy by completing the “Provider Assurance Statement for Telemedicine”.

Limited to three sessions per week per recipient. Payment not available for sending materials to a recipient, other providers or other facilities.
Medicaid Telehealth Reimbursement

Store-and-Forward

Eligible Services/Specialties

Noncovered services:

- Electronic connections that are not conducted over a secure encrypted website as specified by HIPAA
- Scheduling a test or appointment
- Clarification of issues from a previous visit
- Reporting test results
- Non-clinical communication
- Communication via telephone, email or fax

Eligible providers:

- Speech-language pathologists
- Physical therapists
- Physical therapist assistants
- Occupational therapists
- Occupational therapy assistants
- Audiologists

Physical therapist assistants and occupational therapy assistants providing services via telemedicine must follow the same supervision policy as indicated in “Rehabilitation Service Practitioners”. No distant site limitations beyond provider types. Providers must self-attest that they meet all of the conditions of MHCP telemedicine policy by completing the "Provider Assurance Statement for Telemedicine”. See manual for documentation requirements.


Authorized originating sites include:

- Office of physician or practitioner
- Hospital (inpatient or outpatient)
- Critical access hospital (CAH)
- Rural health clinic (RHC) and Federally Qualified Health Center (FQHC)
- Hospital-based or CAH-based renal dialysis center (including satellites)
- Skilled nursing facility (SNF)
- End-stage renal disease (ESRD) facilities
- Community mental health center
- Dental clinic
- Residential facilities, such as a group home and assisted living, shelter or group housing
- Home (a licensed or certified health care provider may need to be present to facilitate the delivery of telemedicine services provided in a private home)
- School
- Correctional facility-based office


Dental

Eligible Originating Sites:

- Health care facility
- Long-term care facility
- Public health agency or institution
- Public or private school authority
- Private non-profit or charitable organizations
- Social services agency or program
- Residential setting in the presence of licensed healthcare providers
| Medicaid Telehealth Reimbursement |  |
|-----------------------------------|  |
| **Store-and-Forward**             |  |
| **Geographic Limits**             |  |
| Affiliate practice or originator within Minnesota Board of Dentistry defined scope of practice must be present at originating site: |  |
| • Dentist |  |
| • Advanced dental therapists |  |
| • Dental therapists |  |
| • Dental hygienists |  |
| • Licensed dental assistants |  |
| • Other licensed health care professionals |  |

|  |  |
| **Rehabilitation Services** |  |
| Eligible originating sites: |  |
| • Office of physician or practitioner |  |
| • Hospital (inpatient or outpatient) |  |
| • Critical access hospital (CAH) |  |
| • Rural health clinic (RHC) and Federally Qualified Health Center (FQHC) |  |
| • Hospital-based or CAH-based renal dialysis center (including satellites) |  |
| • Skilled nursing facility (SNF) |  |
| • End-stage renal disease (ESRD) facilities |  |
| • Community mental health center |  |
| • Dental clinic |  |
| • Residential facilities, such as a group home and assisted living |  |
| • Home (a licensed or certified health care provider may need to be present to facilitate the delivery of telemedicine services provided in a private home) |  |
| • School |  |

|  |  |
| **Transmission Fee** |  |
| No reference found. |  |

|  |  |
| **Remote Patient Monitoring** |  |
| **Policy** |  |
| There is reimbursement for “telehomecare” under Elderly Waiver (EW) and Alternative Care (AC) programs. |  |
| **Source:** MN Dept. of Human Svcs., Provider Manual, Elderly Waiver (EW) and Alternative Care (AC) Program, As revised 5/22/18, (Accessed Sept. 2018). |  |
| Prior authorization for home care services is required for all tele-home-care visits. |  |

<p>| | |
|  |  |
| <strong>Conditions</strong> |  |
| No reference found. |  |</p>
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Remote Patient Monitoring</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Provider Limitations</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Other Restrictions</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Email / Phone / Fax</strong></td>
</tr>
<tr>
<td>No reimbursement for email</td>
</tr>
<tr>
<td>No reimbursement for phone</td>
</tr>
<tr>
<td>No reimbursement for fax</td>
</tr>
<tr>
<td>“A communication between two physicians that consists solely of a telephone conversation, e-mail or facsimile transmission does not constitute a telemedicine consultation or service.”</td>
</tr>
<tr>
<td><strong>Source:</strong> MN Statute Sec. 256B.0625, Subsection 3(b)(d).</td>
</tr>
<tr>
<td>Case management for Child Welfare Case Management services is covered through telephone in certain circumstances.</td>
</tr>
<tr>
<td><strong>Consent</strong></td>
</tr>
<tr>
<td>For alcohol and drug abuse services, the member must have consented to receiving services over telemedicine.</td>
</tr>
<tr>
<td><strong>Out of State Providers</strong></td>
</tr>
<tr>
<td>Out-of-state coverage policy applies to services provided via telemedicine. See out-of-state providers section of manual.</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Early Intensive Developmental and Behavioral Intervention (EIDBI) services</strong></td>
</tr>
<tr>
<td>Services must be:</td>
</tr>
<tr>
<td>• Documented in the person’s individual treatment plan (ITP)</td>
</tr>
<tr>
<td>• Compliant with HIPAA and security requirements and regulation</td>
</tr>
<tr>
<td>• Medically appropriate to the condition and needs of the person and/or family.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th><strong>Definitions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>“Telemedicine” means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient’s health care.</td>
</tr>
</tbody>
</table>

**Source:** MN Statute Sec. 62A.67.

<table>
<thead>
<tr>
<th><strong>Requirements</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Private payers are required to provide coverage for telemedicine in the same manner, and at the same reimbursement rate, as other services provided in-person.</td>
</tr>
<tr>
<td>A health carrier can establish criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a service via telemedicine. They can also require a health care provider to agree to certain documentation or billing practices to protect against fraud.</td>
</tr>
</tbody>
</table>

**Source:** MN Statute Sec. 62A.672.

<table>
<thead>
<tr>
<th><strong>Parity</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Parity</strong></td>
</tr>
<tr>
<td>A health carrier shall reimburse on the same basis that would apply to those services if the service had been delivered in-person. However, the carrier can establish criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a service via telemedicine. They can also require a health care provider to agree to certain documentation or billing practices to protect against fraud.</td>
</tr>
</tbody>
</table>

**Source:** MN Statute Sec. 62A.672.

<table>
<thead>
<tr>
<th><strong>Payment Parity</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A health carrier must reimburse at the same rate as the health carrier would for in-person delivered services.</td>
</tr>
</tbody>
</table>

**Source:** MN Statute Sec. 62A.672.
### Definitions

“Telemedicine” means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient’s health care.

**Source:** MN Statute Sec 147.033.

### Consent

No reference found.

### Online Prescribing

A physician-patient relationship may be established through telemedicine.

**Source:** MN Statute 147.033.

A prescription or drug order is not valid unless it can be established that the prescription or order was based on a documented patient evaluation, including an examination, adequate to establish a diagnosis and identify underlying conditions and contraindications to treatment.

This includes the referring provider performing an in-person examination and a consultant issuing the prescription when providing services by telemedicine.

**Source:** MN Statute Sec. 151.37.

### Cross-State Licensing

A physician licensed in another state can provide telemedicine services to a patient in Minnesota if their license has never been revoked or restricted in any state, they agree to not open an office in Minnesota, meet with patients in Minnesota, or receive calls in Minnesota from patients and they register with the state’s board.

**Source:** MN Statute Sec. 147.032.

Minnesota adopted the Federation of State Medical Board (FSMB)’s model language for an interstate medical licensure compact.

**Source:** MN Senate File 253 (2015). MN Statute Sec. 147.38.

### Miscellaneous

No reference found.
Medicaid Program: Mississippi Medicaid
Program Administrator: Mississippi Division of Medicaid
Regional Telehealth Resource Center: South Central Telehealth Resource Center
Covers the States of: Arkansas, Mississippi & Tennessee
www.learntelehealth.org

Mississippi Medicaid reimburses certain providers for live video telehealth when there is a telemesrerter with the patient. They also reimburse for store-and-forward teleradiology, and for remote patient monitoring for patients with certain chronic conditions.

Telemedicine means the delivery of health care services such as diagnosis, consultation, or treatment through the use of interactive audio, video or other electronic media. Telemedicine must be “real-time” consultation, and it does not include the use of audio-only telephone, e-mail or facsimile.


The Division of Medicaid defines telemedicine as a method which uses electronic information and communication equipment to supply and support health care when remoteness disconnects patients and links primary care physicians, specialists, providers, and beneficiaries which includes, but is not limited to, telehealth services, remote patient monitoring services, teleradiology services, store-and-forward and continuous glucose monitoring services.

The Division of Medicaid defines telehealth services as the delivery of health care by an enrolled Medicaid provider, through a real-time communication method, to a beneficiary who is located at a different site. The interaction must be live, interactive, and audiovisual.


Telehealth service is defined as the practice of health care delivery by a provider to a beneficiary who is under the care of a provider at a different geographical location.

Mississippi Medicaid and private payers are required to provide coverage for live video consultations.


Telehealth services allowed when delivered by an enrolled Medicaid provider acting within their scope of practice and license and in accordance with state and federal guidelines, including authorization of prescription medication at both the originating and distant site.


Medicaid covers medically necessary health services via telehealth when that service is covered in an in-person setting and is live, interactive and audiovisual.


The Division of Medicaid covers medically necessary telehealth services as a substitution for an in-person visit or encounter for consultations, office visits and/or outpatient visits.

**Noncovered Services:**
- Telehealth services in the inpatient setting;
- Separate reimbursement for installation or maintenance of telehealth equipment;
- The following modalities, which MS Medicaid does not consider telehealth: telephone conversation, chart review, electronic mail messages, facsimile transmission, internet services for online medical evaluations, or communication through social media.

The Division of Medicaid reimburses a provider delivering the medically necessary telehealth service at the distant site the current applicable MS Medicaid fee for the service provided if it is a service covered in an in-person setting.

**Source:** MS Admin. Code Title 23, Part 225, Rule. 1.3-1.5 (Accessed Sept. 2018).

There is live video reimbursement for Medicaid mental health medication evaluation and management.


Any enrolled Medicaid provider may provide telehealth services at the originating site. The following enrolled Medicaid providers may provide telehealth services at the distant site:
- Physicians,
- Physician assistants,
- Nurse practitioners,
- Psychologists,
- Licensed Clinical Social Workers (LCSW),
- Licensed Professional Counselors (LPCs),
- Board Certified Behavior Analysts or Board Certified Behavior Analyst Doctorals

Medicaid Telehealth Reimbursement

Eligible Sites

There must be an enrolled Medicaid provider that performs the duties of the telepresenter at the originating site by:

- Acting within their scope-of-practice and license and be physically present in the room at all times during the telehealth service; or
- Providing direct supervision to qualified healthcare professionals acting within their scope of practice who must be an enrolled Medicaid provider and be physically present during the entirety of the telehealth service.


An originating site fee is covered in the following originating sites:

- Office of a physician or practitioner;
- Outpatient Hospital (including a Critical Access Hospital (CAH));
- Rural Health Clinic (RHC);
- Federally Qualified Health Center (FQHC);
- Community Mental Health/Private Mental Health Centers;
- Therapeutic Group Homes;
- Indian Health Service Clinic; or
- School-based clinic.


Facility/Transmission Fee

The Division of Medicaid reimburses the originating site the Mississippi Medicaid telehealth originating site facility fee for telehealth services per completed transmission.

The following enrolled Medicaid providers are eligible to receive the originating site facility fee for telehealth services per transmission:

- Office of a physician or practitioner,
- Outpatient hospital, including a Critical Access Hospital (CAH),
- Rural Health Clinic (RHC),
- Federally Qualified Health Center (FQHC),
- Community Mental Health/Private Mental Health Centers,
- Therapeutic Group Home,
- Indian Health Service Clinic, and
- School-based clinic.

In order for the originating site to receive the originating site facility fee the telepresenter must be an enrolled Medicaid provider:

- Acting within their scope-of-practice and license and physically present in the room at all times during the telehealth service, or
- Providing direct supervision to a qualified healthcare professional acting within their scope-of-practice who is physically present in the room at times during the telehealth service.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Facility/Transmission Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Live Video</strong></td>
<td>Facility fee provided per completed transmission.</td>
</tr>
<tr>
<td>RHCs and FQHCs acting in the role of a telehealth originating site provider with no other separately identifiable service being provided will only be paid the telehealth originating site fee per completed transmission and will not receive reimbursement for an encounter.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Store-and-Forward</strong></th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private payers, MS Medicaid and employee benefit plans are required to provide coverage at the same level as in-person consultation for store-and-forward telemedicine services.</td>
<td></td>
</tr>
<tr>
<td>A health insurance or employee benefit plan can limit coverage to health care providers in a telemedicine network approved by the plan.</td>
<td></td>
</tr>
<tr>
<td>Patients receiving medical care through store-and-forward must be notified of their right to receive interactive communication with the distant site provider. Telemedicine networks unable to offer this will not be reimbursed for store-and-forward telemedicine services.</td>
<td></td>
</tr>
<tr>
<td>Telehealth services must be live, interactive and audiovisual.</td>
<td></td>
</tr>
<tr>
<td>There is reimbursement for tele-radiology services, however there is no reference to reimbursing for other specialties in regulation.</td>
<td></td>
</tr>
<tr>
<td>A consulting provider is a licensed physician that interprets the radiological images and is licensed in the state within the US in which he/she practices and distant site as the location of the teleradiology consulting provider. The referring provider is defined as a licensed physician, physician assistant or nurse practitioner who orders the radiological service who must be licensed in the state within the United States which he/she practices.</td>
<td></td>
</tr>
</tbody>
</table>

| **Eligible Services/Specialties** | | |
|---------------------------------|-----------------|
| Store-and-forward includes, but is not limited to teleradiology. The Division of Medicaid covers one technical and one professional component for each teleradiology procedure only for providers enrolled in MS Medicaid and when there are no geographically local radiologist providers to interpret the images. |

<table>
<thead>
<tr>
<th><strong>Geographic Limits</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MS Medicaid only covers teleradiology when there are no geographically local radiologist providers to interpret images.</td>
<td></td>
</tr>
<tr>
<td><strong>Source:</strong> MS Admin. Code Title 23, Part 225, Rule. 3.3 (Accessed Sept. 2018).</td>
<td></td>
</tr>
</tbody>
</table>
### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Store-and-Forward</th>
<th>Transmission Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>No transmission fee.</td>
<td></td>
</tr>
</tbody>
</table>

Private payers, MS Medicaid and employee benefit plans are required to provide coverage for remote patient monitoring services for Mississippi-based telehealth programs affiliated with a Mississippi health care facility.

A one-time telehealth installation/training fee is also reimbursed.


The Division of Medicaid reimburses for remote patient monitoring:

- Of devices when billed with the appropriate code, and
- For disease management:
  - A daily monitoring rate for days the beneficiary’s information is reviewed.
  - Only one (1) unit per day is allowed, not to exceed thirty-one (31) days per month.
  - An initial visit to install the equipment and train the beneficiary may be billed as a set-up visit. Only one set-up is allowed per episode even if monitoring parameters are added after the initial set-up and installation.
  - Only one (1) daily rate will be reimbursed regardless of the number of diseases/chronic conditions being monitored.


To qualify for reimbursement patients must meet all of the following criteria:

- Be diagnosed in the last 18 months with one or more chronic condition, as defined by CMS.
- Have a recent history of costly services use due to one or more chronic conditions as evidenced by two or more hospitalizations, including emergency room visits in the past twelve months; and
- The patient’s healthcare provider recommends disease management services via remote patient monitoring.


The Division of Medicaid covers remote patient monitoring, for disease management when medically necessary, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), Division of Medicaid or designee, ordered by a physician, physician assistant, or nurse practitioner for a beneficiary who meets the following criteria:

- Has been diagnosed with one (1) or more of the following chronic conditions of diabetes, congestive heart failure (CHF), or chronic obstructive pulmonary disease (COPD);
- Has had two (2) or more hospitalizations in the previous twelve (12) months for one (1) of the chronic conditions listed above;
- Hospitalizations for two (2) different chronic conditions cannot be combined to satisfy the two (2) or more hospitalizations requirement; and
- Is capable of using the remote patient monitoring equipment and transmitting the necessary data or has a willing and able person to assist in completing electronic transmission of data.
The Division of Medicaid covers remote patient monitoring of devices when medically necessary, ordered by a physician, physician assistant or nurse practitioner which includes, but not limited to:

- Implantable pacemakers,
- Defibrillators,
- Cardiac monitors,
- Loop recorders, and
- External mobile cardiovascular telemetry.


Remote patient monitoring services must be delivered by an enrolled Medicaid provider acting within their scope-of-practice and license and in accordance with state and federal guidelines. Must be ordered by a physician, physician assistant or nurse practitioner.


A health insurance or employee benefit plan can limit coverage to health care providers in a telemedicine network approved by the plan.


Remote patient monitoring prior authorization request form must be submitted to request telemonitoring services.

The law lists specific technology requirements.


Remote patient monitoring services must be provided in the beneficiary’s private residence.


No reimbursement for email. No reimbursement for telephone. No reimbursement for facsimile.


Not considered telehealth:

- Telephone conversations;
- Chart reviews;
- Electronic mail messages;
- Facsimile transmission;
- Internet services for online medical evaluations; or
- The installation or maintenance of any telecommunication devices or systems.


Signed consent for using telehealth is required.

### Medicaid Telehealth Reimbursement

**Out of State Providers**

For teleradiology, consulting and referring provider is a licensed physician (or PA or NP for referring providers) who interprets the radiological image, at the distant site and who must be licensed in the state within the United States in which he/she practices.


**Miscellaneous**

See documentation requirements.


### Private Payer Laws

**Definitions**

Telemedicine means the delivery of health care services such as diagnosis, consultation, or treatment through the use of interactive audio, video or other electronic media. Telemedicine must be “real-time” consultation, and it does not include the use of audio-only telephone, e-mail or facsimile.


**Worker’s Compensation**

“Telemedicine is 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 definition does not include the practice of medicine through postal or courier services.”


**Requirements**

A health insurance or employee benefit plan can limit coverage to health care providers in a telemedicine network approved by the plan.

All health insurance and employee benefit plans in this state must provide coverage for telemedicine services to the same extent that the services would be covered if they were provided through in-person consultation.

A health insurance or employee benefit plan is not prohibited from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered person’s policy.

The originating site is eligible to receive a facility fee.


**Store-and-forward and Remote Patient Monitoring**

All health insurance and employee benefit plans in this state must provide coverage and reimbursement for the asynchronous telemedicine services of store-and-forward telemedicine services and remote patient monitoring services based on the criteria set out in this section.
To qualify for remote patient monitoring services, patients must meet all of the following criteria:

- Be diagnosed in the last 18 months with one or more chronic conditions, as defined by CMS;
- Have a recent history of costly services due to one or more chronic conditions as evidenced by two or more hospitalizations, including emergency room visits in the last 12 months; and
- The patient’s healthcare provider recommends disease management services via remote patient monitoring.

Patients receiving medical care through store-and-forward must be notified of their right to receive interactive communication with the distant site specialist health care provider and shall receive an interactive communication with the distant specialist upon request. If requested, the communication may occur at the time of consultation or within 30 days of the patient’s request. Telemedicine networks unable to offer this will not be reimbursed for store-and-forward telemedicine services.

Remote patient monitoring prior authorization request form must be submitted to request telemonitoring services and include:

- An order for home telemonitoring, signed and dated by a prescribing physician
- A plan of care, signed and dated by the prescribing physician
- The client’s diagnosis and risk factors that qualify the client for home telemonitoring services
- Attestation that the client is sufficiently cognitively intact and able to operate the equipment or has a willing and able person to assist
- Attestation that the client is not receiving duplicative services via disease management services.

The entity providing remote patient monitoring must be located in Mississippi and have protocols in place meeting specified criteria listed in Mississippi law.

The law lists specific technology requirements, non-English language options, and 24/7 technical and clinical support services available.

Monitoring of a client’s data cannot be duplicated by another provider.

The service must include

- An assessment, problem identification, and evaluation including:
  - Assessment and monitoring of clinical data
  - Detection of condition changes based on the telemedicine encounter
- Implementation of a management plan through one or more of the following:
  - Teaching regarding medication management
  - Teaching regarding other interventions
  - Management and evaluation of the plan of care
  - Coordination of care with the ordering health care provider
  - Coordination and referral to other medical providers as needed
  - Referral for an in-person visit or the emergency room as needed

### Private Payer Laws

**Parity**

All health insurance plans must provide coverage for telemedicine services, including live video and store-and-forward, to the same extent as in-person consultations. Remote patient monitoring is also reimbursed based on the criteria outlined in MS code.

A health insurance plan may charge a deductible, co-payment, or coinsurance for a health care service provided through telemedicine so long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

A health insurance or employee benefit plan can limit coverage to health care providers in a telemedicine network approved by the plan.


**Payment Parity**

No explicit payment parity.

**Remote Patient Monitoring Reimbursement**

Remote patient monitoring services are required to include reimbursement for a daily monitoring rate at a minimum of ten dollars per day each month and sixteen dollars per day when medication adherence management services are included, not to exceed 31 days per month.

A one-time installation/training fee for remote patient monitoring services will also be reimbursed at a minimum rate of fifty dollars per patient, with a maximum of two installation/training fees per calendar year.

These reimbursement rates are only eligible to Mississippi-based telehealth programs affiliated with a Mississippi health care facility.


### Professional Regulation/Health & Safety

**Definitions**

**Practice of Medicine**

Telemedicine is 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 definition does not include the practice of medicine through postal or courier services.


**Cross-State Practice**

Telemedicine, or the practice of medicine across state lines, shall be defined to include any one or both of the following:

- Rendering of a medical opinion concerning diagnosis or treatment of a patient within this state by a physician located outside this state as a result of transmission of individual patient data by electronic or other means from within this state to such physician or his agent; or
- The rendering of treatment to a patient within this state by a physician located outside this state as a result of transmission of individual patient data by electronic or other means from within this state to such physician or his agent.

*Source: MS Code Sec. 73-25-34(1). (Accessed Sept. 2018)*

**Consent**

The physician should obtain the patient’s informed consent before providing care. The patient should be provided with information relative to treatment, the risk and benefits of being treated via a telemedicine network and how to receive follow-up care or assistance.

*Source: MS Admin. Code Title 30, Sec. 2635, Rule 5.3. (Accessed Sept. 2018)*
Online Prescribing

A prescription for a controlled substance based solely on a consumer’s completion of an online medical questionnaire is not a valid prescription.


To establish the physician patient relationship through telemedicine, it must include:

- Verify the identity of the person;
- Conduct an appropriate history and physical examination (which can be conducted via telemedicine);
- Establish a diagnosis through the use of acceptable medical practice;
- Discuss with the patient the diagnosis, risks and benefits of various treatment options to obtain informed consent;
- Insuring the availability of appropriate follow up care; and
- Maintaining a complete medical record available to patient and other treating health care providers.

Physicians using telemedicine to provide medical care must provide an appropriate examination prior to diagnosis and treatment of a patient. The exam does not need to be in-person if the technology is sufficient to provide the same information to the physician as if the exam had been performed face-to-face.


Cross-State Licensing

No person may engage in the practice of medicine across state lines in Mississippi unless they first obtain a license to do so from the State Board of Medical Licensure and meet all educational and licensure requirements as determined by the Board. These requirements are not required where the evaluation, treatment and/or the medical opinion to be rendered by a physician outside the state is requested by a physician duly licensed to practice medicine in the state, and the physician who has requested the evaluation, treatment and/or medical opinion has already established a doctor/patient relationship with the patient to be evaluated and/or treated.


The practice of medicine is deemed to occur in the location of the patient, therefore physicians practicing telemedicine must have a Mississippi medical license. The interpretation of clinical laboratory studies as well as pathology and histopathology studies performed by physicians without Mississippi licensure is not the practice of telemedicine if a Mississippi licensed physician is responsible for accepting, rejecting, or modifying the interpretation.


Member of the Interstate Medical Licensure Compact.


Member of the Nurse Licensure Compact.


Member of the Physical Therapy Compact.

A physician treating a patient through a telemedicine network must maintain a complete record of the patient’s care.

No physician practicing teleemergency medicine shall be authorized to function in a collaborative/consultative role unless their practice location is a Level One Hospital Trauma Center that is able to provide continuous twenty-four hour coverage and has an existing air ambulance system in place. Coverage will be authorized only for those emergency departments of licensed hospitals who have an average daily census of thirty or fewer acute care/medical surgical occupied beds as defined by their Medicare Cost Report.

**Medicaid Program:** HealthNet  
**Program Administrator:** Missouri Dept. of Social Services  
**Regional Telehealth Resource Center:** Heartland Telehealth Resource Center  
**Covers the States of:** Kansas, Missouri & Oklahoma

### Summary

*A Feb. 2018 Medicaid Bulletin states that MO regulation Title 13, 70-3.190 will soon be rescinded and to not follow this regulation. To view the telehealth requirements contained in this regulation, reference the regulatory text (see source).*


### Definitions

“Telehealth” or “telemedicine”, the delivery of health care services by means of information and communication technologies which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while such patient is at the originating site and the health care provider is at the distant site. Telehealth or telemedicine shall also include the use of asynchronous store-and-forward technology.

**Source:** MO Revised Statute Title XII Public Health and Welfare Sec. 208.670 which references Title XII Sec. 191.1145.

Telehealth Services are medical services provided through advanced telecommunications technology from one location to another. Medical information is exchanged in real-time communication from an originating site, where the participant is located, to a distant site, where the provider is located, allowing them to interact as if they are having a face-to-face, hands-on session.

A Telehealth service requires the use of a two (2)-way interactive video technology.


### Live Video Policy

The department of social services shall reimburse providers for services provided through telehealth if such providers can ensure services are rendered meeting the standard of care that would otherwise be expected should such services be provided in-person. Reimbursement for telehealth services shall be made in the same way as reimbursement for in-person contact; however, consideration shall also be made for reimbursement to the originating site.

**Source:** MO Revised Statute Ch. 208 Sec. 208.670.

Telehealth services are only covered if medically necessary.

Medicaid Telehealth Reimbursement

Coverage is limited to:

- Consultations made to confirm a diagnosis; or
- Evaluation and management services; or
- A diagnosis, therapeutic, or interpretative service; or
- Individual psychiatric or substance abuse assessment diagnostic interview examinations; or
- Individual psychotherapy
- Pharmacologic management (for RHCs)


POS 02 should be used for telehealth furnished from the distant site. Distant services provided on school grounds should be billed with POS 03 and a GT modifier.


Rural Health Clinics (As Distant Site Providers)

Eligible services:

- Consultations
- Office or other outpatient visits
- Psychiatric diagnostic procedures
- Psychotherapy


Eligible providers:

- Physicians;
- Advanced registered Nurse Practitioners, including Nurse Practitioners with a mental health specialty;
- Psychologists.


RHCs must bill with their non-RHC provider number when they are either the distant or originating site to receive the facility fee.


Comprehensive Substance Treatment and Rehabilitation (CSTAR):

Medication services may be provided via telehealth.


Anesthesiologist monitoring telemetry in the operating room is a non-covered service.

The department shall not restrict the originating site through rule or payment so long as the provider can ensure services are rendered meeting the standard of care that would otherwise be expected should such services be provided in-person.

**Source:** MO Revised Statute Ch. 208 Sec. 208.670.

No originating site for services or activities provided under this section shall be required to maintain immediate availability of on-site clinical staff during the telehealth services, except as necessary to meet the standard of care for the treatment of the patient’s medical condition if such condition is being treated by an eligible health care provider who is not at the originating site, has not previously seen the patient in-person in a clinical setting, and is not providing coverage for a health care provider who has an established relationship with the patient.

**Source:** MO Revised Statute Sec. 191.1145.

RHCs must bill with their non-RHC provider number when they are either the distant or originating site to receive the facility fee.


The originating site is where the MO HealthNet participant receiving the telehealth service is physically located. The originating site and distant site can be billed by the same provider for the same date of service as long as the distant site is not located in the originating site facility.


Originating sites must be one of the following:

- Physician or other health care provider office;
- Hospital;
- Critical Access Hospital;
- Rural Health Clinic;
- Federally Qualified Health Center;
- Missouri state habilitation center or regional office;
- Community mental health center;
- Missouri state mental health facility;
- Missouri state facility.


RHCs must bill with their non-RHC provider number when they are either the distant or originating site to receive the facility fee.


Payment for services rendered via telehealth shall not depend on any minimum distance requirement between the originating and distant site.

**Source:** MO Revised Statute Ch. 208 Sec. 208.670.
Reimbursement for telehealth services shall be made in the same way as reimbursement for in-person contact; however, consideration shall also be made for reimbursement to the originating site.

Source: MO Revised Statute Ch. 208 Sec. 208.670.

Providers can bill Q3014 for the telehealth originating site facility fee.


FQHCs and RHCs are eligible for an originating site facility fee.


Originating sites are eligible to receive a facility fee; distant sites are not eligible. The cost of an optional telepresenter is included in the facility fee.


Reimbursement for asynchronous store-and-forward may be capped at the reimbursement rate had the service been provided in-person.

Source: MO Revised Statute Ch. 208 Sec. 208.670.

HealthNet will not reimburse for store-and-forward.


No reference found.
Subject to appropriations, the department shall establish a statewide program that permits reimbursement under the MO HealthNet program for home telemonitoring services.

**Source:** MO Revised Statute Sec. 208.686.

Personal Emergency Response Systems (an electronic device that is programmed to signal a response center once the help button is activated) is available for patients at high risk of being institutionalized.


<table>
<thead>
<tr>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible conditions:</td>
</tr>
<tr>
<td>- Pregnancy</td>
</tr>
<tr>
<td>- Diabetes</td>
</tr>
<tr>
<td>- Heart disease</td>
</tr>
<tr>
<td>- Cancer</td>
</tr>
<tr>
<td>- Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>- Hypertension</td>
</tr>
<tr>
<td>- Congestive heart failure</td>
</tr>
<tr>
<td>- Mental illness or serious emotional disturbance</td>
</tr>
<tr>
<td>- Asthma</td>
</tr>
<tr>
<td>- Myocardial infarction or stroke</td>
</tr>
</tbody>
</table>

The beneficiary must also exhibit two or more the following risk factors:

- Two or more hospitalizations in the prior twelve-month period;
- Frequent or recurrent emergency department admissions;
- A documented history of poor adherence to ordered medication regimens;
- A documented history of falls in the prior six-month period;
- Limited or absent informal support systems;
- Living alone or being home alone for extended periods of time;
- A documented history of care access challenges; or
- A documented history of consistently missed appointments with health care providers.

**Source:** MO Revised Statute Sec. 208.686.

The program must ensure the home health agency or hospital shares telemonitoring clinical information with participant’s physician.

**Source:** MO Revised Statute Sec. 208.686.

If, after implementation, the department determines that the program established under this section is not cost effective, the department may discontinue the program and stop providing reimbursement under the MO HealthNet program for home telemonitoring services. The department shall promulgate rules and regulations to implement the provisions of this section.

**Source:** MO Revised Statute Sec. 208.686.
### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Email / Phone / Fax** | No reimbursement for email. No reimbursement for phone. No reimbursement for fax. No reimbursement for a consultation between healthcare providers. No reimbursement for services provided via videophone.  
| **Consent** | Prior to the provision of telehealth services in a school, the parent or guardian of the child shall provide authorization for the provision of such service. Such authorization shall include the ability for the parent or guardian to authorize services via telehealth in the school for the remainder of the school year.  
**Source:** MO Revised Statute, XII Public Health and Welfare. Ch. 208, Sec. 208.677.  
Providers must obtain written patient consent before delivery of telehealth services. Each of the written information must be provided in a format and manner that the participant can understand:  
- The participant shall have the option to refuse the Telehealth service at anytime without affecting the right to future care and treatment and without risking the loss or withdrawal of a MO HealthNet benefit to which the participant is entitled;  
- The participant shall be informed of alternatives to the Telehealth service that are available to the participant;  
- The participant shall have access to medical information resulting from the Telehealth service as provided by law;  
- The dissemination, storage, or retention of an identifiable participant image or other information from the Telehealth service must not occur without the written informed consent of the participant or the participant’s legally authorized representative;  
- The participant shall have the right to be informed of the parties who will be present at the originating site and the distant site during the Telehealth service and shall have the right to exclude anyone from either site; and  
- The participant shall have the right to object to the videotaping or other recording of a Telehealth service.  
| **Out of State Providers** | Payment cannot be made to entities outside of the US, and US territories.  
| **Miscellaneous** | Special documentation requirements apply.  
A telehealth service must be performed on a private dedicated telecommunications line approved through the Missouri Telehealth Network (MTN).  
### Private Payer Laws

#### Definitions

"Telehealth" or "telemedicine", the delivery of health care services by means of information and communication technologies which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while such patient is at the originating site and the health care provider is at the distant site. Telehealth or telemedicine shall also include the use of asynchronous store-and-forward technology.

**Source:** MO Revised Statute Title XXIV Business and Professions, Sec. 376.1900, which references Sec. Title XII Public Health and Welfare Sec. 208.780 which references Title XII Sec. 191.1145.

#### Requirements

Health carriers shall not deny coverage for a health care service on the basis that the health care service is provided through telehealth if the same service would be covered if provided through face-to-face diagnosis, consultation, or treatment.

A health carrier may not exclude an otherwise covered health care service from coverage solely because the service is provided through telehealth rather than face-to-face consultation or contact between a health care provider and a patient.

A health carrier shall not be required to reimburse a telehealth provider or a consulting provider for site origination fees or costs for the provision of telehealth services; however, subject to correct coding, a health carrier shall reimburse a health care provider for the diagnosis, consultation, or treatment of an insured or enrollee when the health care service is delivered through telehealth on the same basis that the health carrier covers the service when it is delivered in-person.

A health carrier or health benefit plan may limit coverage for health care services that are provided through telehealth to health care providers that are in a network approved by the plan or the health carrier.

**Source:** MO Revised Statutes § 376.1900.

**Missouri Consolidated Health Care Plan (State employees and retirees health plan)**

Telehealth services are covered on the same basis that the service would be covered when it is delivered in-person. Telehealth site origination fees or costs for the provision of telehealth services are not covered.

**Source:** MO Consolidated State Reg. 22:10-3.057.

#### Parity

**Service Parity**

A health carrier may not exclude an otherwise covered health care service from coverage solely because the service is provided through telehealth rather than face-to-face consultation or contact between a health care provider and a patient. A health carrier or health benefit plan may limit coverage for health care services that are provided through telehealth to health care providers that are in a network approved by the plan or the health carrier.

**Source:** MO Revised Statutes § 376.1900.

**Payment Parity**

No explicit payment parity.
“Telehealth” or “telemedicine”, the delivery of health care services by means of information and communication technologies which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while such patient is at the originating site and the health care provider is at the distant site. Telehealth or telemedicine shall also include the use of asynchronous store-and-forward technology.

Source: MO Revised Statute Sec. 191.1145.

**Licensing of Physicians and Surgeons**

Telehealth means the use of medical information exchanged from one site to another via electronic communications to improve the health status of a patient.

Source: MO Code of State Regulation. Title 20, 2150-2.001.

**Collaborative Care Arrangement**

Telehealth providers (including Advanced Practice Registered Nurses who are providing nursing services under a collaborative practice arrangement) are required to obtain patient (or the patient’s guardian’s) consent and document consent in patient’s record.

Source: MO Code of State Regulation. Title 20, 2150-2.240 & Sec. 20, 2150-5.100 & MO Revised Statute Title XXII Occupations and Professions Ch. 335.175.

**Online Prescribing**

Prescribing or dispensing drugs without sufficient examination is prohibited.

Source: MO Revised Statutes § 334.100(2)(h).

A telemedicine encounter can establish a physician-patient relationship if the standard of care does not require an in-person encounter and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

In order to establish a physician-patient relationship through telemedicine:

- The technology utilized shall be sufficient to establish an informed diagnosis as though the medical interview and physical examination has been performed in-person; and
- Prior to providing treatment, including issuing prescriptions, a physician who uses telemedicine shall interview the patient, collect or review relevant medical history, and perform an examination sufficient for the diagnosis and treatment of the patient. A questionnaire completed by the patient, whether via the internet or telephone, does not constitute an acceptable medical interview and examination for the provision of treatment by telehealth.

Source: MO Revised Statute Ch. 191 Sec. 191.1146.

In addition, in order to prescribe, the relationship includes:

- Obtaining a reliable medical history and performing a physical examination of the patient, adequate to establish the diagnosis for which the drug is being prescribed and to identify underlying conditions or contraindications to the treatment recommended or provided;
- Having sufficient dialogue with the patient regarding treatment options and the risks and benefits of treatment or treatments;
- If appropriate, following up with the patient to assess the therapeutic outcome;
- Maintaining a contemporaneous medical record that is readily available to the patient and, subject to the patient’s consent, to the patient’s other health care professionals; and
- Maintaining the electronic prescription information as part of the patient’s medical record.
Online Prescribing

The requirements of subsection 1 (see above) may be satisfied by the prescribing physician's designee when treatment is provided in:

- A hospital;
- A hospice program;
- Home health services provided by a home health agency;
- Accordance with a collaborative practice agreement;
- Conjunction with a physician assistant licensed;
- Conjunction with an assistant physician;
- Consultation with another physician who has an ongoing physician-patient relationship with the patient, and who has agreed to supervise the patient's treatment, including use of any prescribed medications; or
- On-call or cross-coverage situations.

No health care provider shall prescribe any drug, controlled substance, or other treatment to a patient based solely on an evaluation over the telephone; except that, a physician, such as a physician's on-call designee, an advanced practice registered nurse in a collaborative practice arrangement with such physician, a physician assistant in a supervision agreement with such physician, or an assistant physician in a supervision agreement with such physician may prescribe any drug, controlled substance, or other treatment that is within his or her scope of practice to a patient based solely on a telephone evaluation if a previously established and ongoing physician-patient relationship exists between such physician and the patient being treated.

No health care provider shall prescribe any drug, controlled substance, or other treatment to a patient based solely on an internet request or an internet questionnaire.

Source: MO Revised Statute Sec. 334.108.

Cross-State Licensing

In order to treat patients in this state through the use of telemedicine or telehealth, health care providers shall be fully licensed to practice in this state and shall be subject to regulation by their respective professional boards.

Does not apply to:

- Informal consultation performed by a health care provider licensed in another state, outside of the context of a contractual relationship, and on an irregular or infrequent basis without the expectation or exchange of direct or indirect compensation;
- Furnishing of health care services by a health care provider licensed and located in another state in case of an emergency or disaster; provided that, no charge is made for the medical assistance; or
- Episodic consultation by a health care provider licensed and located in another state who provides such consultation services on request to a physician in this state.

Source: MO Revised Statute Ch. 191 Sec. 191.1145.

Member of Psychology Interjurisdictional Compact (PSYPACT).


Member of Physical Therapy Compact.


Member of Nurses Licensure Compact.

No reference found.
Montana Medicaid reimburses for live video under some circumstances. There is no reimbursement for store-and-forward or remote patient monitoring based on the definition for telemedicine.

**Definitions**

Telemedicine is the use of interactive audio-video equipment to link practitioners and patients located at different sites.


**Healthy Montana Kids**

Telemedicine is “the use of a secure interactive audio and video, or other telecommunications technology by a health care provider to deliver health care services at a site other than the site where the patient is located. Does not include audio only (phone call), e-mail, and/or facsimile transmission.”


**Live Video Policy**

MT Medicaid reimburses for medically necessary telemedicine services to eligible members. Providers must be enrolled as Montana Medicaid providers.

Telemedicine should not be used when face-to-face services are medically necessary. Members should establish relationships with primary care providers who are available on a face-to-face basis.

The originating and distant providers may not be within the same facility or community. The same provider may not be the “pay to” for both the originating and distance provider.

**Medicaid Telehealth Reimbursement**

**Healthy Montana Kids**
Services provided by telemedicine are allowed for non-surgical medical services and behavioral health outpatient services.


Telehealth services are available for Speech Therapy when ordered by a physician or mid-level practitioner. The order is valid for 180 days.


**Eligible Services / Specialties**
- Healthy Montana Kids
- Services provided by telemedicine are allowed for non-surgical medical services and behavioral health outpatient services.

**Eligible Providers**
- Outpatient hospital
- Critical access hospital
- Federally qualified health center
- Rural health center
- Indian health service
- Physician
- Psychiatrist
- Mid-levels
- Dieticians
- Psychologists
- Licensed clinical social worker
- Licensed professional counselor
- Mental health center
- Chemical dependency clinic
- Group/clinic
- Public health clinic
- Family planning clinic

The place of service is considered to be the location of the distance provider providing the telemedicine service.


**Eligible Sites**
Telemedicine can be provided in a member’s residence; the distance provider is responsible for the confidentiality requirements.


**Geographic Limits**
The originating and distant providers may not be within the same facility or community or have the same tax ID number.

The following provider types can bill the originating site fee:

- Outpatient hospital
- Critical access hospital
- Federally qualified health center
- Rural health center
- Indian health service
- Physician
- Psychiatrist
- Mid-levels
- Dieticians
- Psychologists
- Licensed clinical social worker
- Licensed professional counselor
- Mental health center
- Chemical dependency clinic
- Group/clinic
- Public health clinic
- Family planning clinic

Originating site providers must include a specific diagnosis code to indicate why a member is being seen by a distance provider and this code must be requested from the distance site prior to billing for the telemedicine appointment.

The originating site provider may also, as appropriate, bill for clinical services provided on-site the same day that a telemedicine originating site service is provided. The originating site may not bill for assisting the distant site provider with an examination, including for any services that would be normally included in a face-to-face visit.


There is no facility fee reimbursement when the originating site is a member’s residence.


No reimbursement for infrastructure or network use charges.


FQHCs and RHCs can bill a telehealth originating site code if applicable.


There is no reimbursement for store-and-forward based on the definition for telemedicine restricting the service to interactive audio-video.


No reference found.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Store-and-Forward</th>
<th>Geographic Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td>Transmission Fee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remote Patient Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Limitations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Restrictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There is no reimbursement for remote patient monitoring based on the definition for telemedicine restricting the service to interactive audio-video.

<table>
<thead>
<tr>
<th>Medicare Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telemedicine reimbursement does not include:</strong></td>
</tr>
<tr>
<td>• Consultation by telephone</td>
</tr>
<tr>
<td>• Facsimile machine transmissions</td>
</tr>
<tr>
<td>• Crisis hotlines</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email / Phone / Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reimbursement for telephone services in home.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out of State Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers must be licensed in the state of Montana.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Jan. 1, 2017 the new place of service code is “02”.</td>
</tr>
<tr>
<td>If a rendering provider’s number is required on the claim for a face-to-face visit, it is required on a telemedicine claim.</td>
</tr>
<tr>
<td>Confidentially requirements apply (see manual).</td>
</tr>
</tbody>
</table>
### Private Payer Laws

#### Definitions

Telemedicine means the use of interactive audio, video, or other telecommunications technology that is:

- Used by a health care provider or health care facility to deliver health care services at a site other than the site where the patient is located; and
- Delivered over a secure connection that complies with the requirements of HIPPA.
  - The term includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.
  - The term does not include the use of audio-only telephone, e-mail, or facsimile transmissions.


#### Requirements

Eligible providers under the parity law include:

- Physicians
- Physician Assistants
- Podiatrists
- Pharmacists
- Optometrists
- Physical Therapists
- Occupational Therapists
- Speech-language Pathologists and Audiologists
- Psychologists
- Social Workers
- Licensed Professional Counselors
- Nutritionists
- Addiction Counselors
- Registered professional nurse
- Advanced practice registered nurse
- Genetic counselor certified by the American board of genetic counseling
- Diabetes educator certified by the national certification board for diabetes
- Dentists & Dental Hygienists

Eligible facilities under this law include:

- Critical access hospital
- Hospice
- Hospital
- Long-term care facility
- Mental health center
- Outpatient center for primary care
- Outpatient center for surgical services

A private insurer is not:

- Required to provide coverage for services that are not medically necessary, subject to the terms and conditions of the policy
- Permitted to require a health care provider to be physically present with the patient at the site where the patient is located unless the distant site provider determines that the presence of a health care provider is necessary.

### Private Payer Laws

#### Parity

Private payers are required to provide coverage for services delivered through telemedicine if the services are otherwise covered by the policy, certificate, contract, or agreement.

Coverage must be equivalent to the coverage for services that are provided in-person by a health care provider or health care facility.


#### Payment Parity

No explicit payment parity.

### Professional Regulation/Health & Safety

#### Definitions

Telemedicine means the practice of medicine using interactive 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. Telemedicine typically involves the application of secure videoconferencing or store-and-forward technology, as defined in 33-22-138. The term does not mean an audio-only telephone conversation, an e-mail or instant messaging conversation, or a message sent by facsimile transmission.


#### Consent

No reference found.

#### Online Prescribing

No reference found.

### Cross-State Licensing

- Member of the Interstate Medical licensure Compact.
  
  **Source:** The IMLC. Interstate Medical Licensure Compact. (Accessed Sep. 2018).

- Member of the Nurse Licensure Compact.
  

- Member of the Physical Therapy Compact.
  
Professional Board Telehealth-Specific Regulations

• MT Board of Speech-Language Pathology (MT Admin Rules, Sec. 24.222.9 (Accessed Sep. 2018).
**Medicaid Program:** Nebraska Medicaid

**Program Administrator:** NE Dept. of Health and Human Services

**Regional Telehealth Resource Center:** Great Plains Telehealth Resource and Assistance Center

**Covers the States of:** Iowa, Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin

[https://www.gptrac.org](https://www.gptrac.org)

---

### Summary

Nebraska Medicaid reimburses for live video, store-and-forward, and remote patient monitoring under some circumstances. Reimbursement for store-and-forward is only specified for teleradiology.

### Definitions

**Telehealth consultation** means any contact between a client and a health care practitioner relating to the health care diagnosis or treatment of such client through telehealth. For the purposes of telehealth, a consultation includes any service delivered through telehealth.

Telemonitoring is the remote monitoring of a client’s vital signs, biometric data, or subjective data by a monitoring device which transmits such data electronically to a health care practitioner for analysis and storage.


Telehealth means the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care practitioner in the diagnosis or treatment of a patient. Telehealth includes services originating from a patient’s home or any other location where such patient is located, asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to or retrieved by a health care practitioner at another site for medical evaluation, and telemonitoring.

*Source: NE Rev. Statute, 71-8503(3).*

### Policy

Nebraska Medicaid provides coverage for telehealth at the same rate as in-person services when the technology meets industry standards and is HIPAA compliant.

Medicaid will reimburse a consulting health care provider if after obtaining and analyzing the transmitted information, the consulting provider reports back to the referring health care practitioner. Payment is not made to the referring health care practitioner who sends the medical documentation.

Practitioner consultation is not covered for behavioral health when the client has an urgent psychiatric condition requiring immediate attention by a licensed mental health practitioner.

*Source: NE Admin. Code Title 471 Sec. 1-006.08-.09, Ch. 1, Manual Letter #52-2016. (Accessed Sep. 2018).*
In-person contact is not required for reimbursable services under the Medicaid program, subject to reimbursement policies developed. This policy also applies to managed care plans who contract with the Department only to the extent that:

- Services delivered via telehealth are covered and reimbursed under the fee-for-service program and
- Managed care contracts are amended to add coverage of services delivered via telehealth and appropriate capitation rate adjustments are incorporated.

Reimbursement shall, at a minimum, be set at the same rate as a comparable in-person consult and the rate must not depend on the distance between the health care practitioner and the patient.

The Department of Health and Human Services will establish rates for transmission cost reimbursement for telehealth consultations, which will include all applicable two-way, real-time, interactive communications, unless provided by an internet service provider.

**Children’s Behavioral Health**

A trained staff member must be immediately available to a child receiving telehealth behavioral health service. This requirement may be waived by a legal guardian and in cases where there is a threat that the child may harm themselves or others, a safety plan must be developed before the telehealth interaction takes place.

**Federally Qualified Health Centers & Rural Health Clinics**

FQHC & RHC core services provided via telehealth are not covered under the encounter rate.

**Assertive Community Treatment (ACT)**

ACT Team Interventions may be provided via telehealth when provided according to certain regulations.

**Indian Health Service (IHS) Facilities**

Telehealth services may be used to conduct a face-to-face visit for the provision of medically necessary Medicaid-defined services in an IHS or Tribal facility.

**Services for Individuals with Developmental Disabilities**

Providers may conduct observations for the development, modification, evaluation, or implementation of a behavioral support plan in-person or by telehealth.

**Eligible Providers**

Nebraska Medicaid-enrolled providers licensed, registered, or certified to practice in Nebraska are eligible for reimbursement.
Medicaid Telehealth Reimbursement

| Eligible Sites | Health care practitioners must assure that the originating sites meet the standards for telehealth, including providing a place where the client’s right for confidential and private services is protected. |

| Geographic Limits | No reference found. |

| Live Video | Nebraska Medicaid reimburses for transmission costs for two-way, real-time interactive communication, unless provided by an internet service provider. An originating site fee is paid to the Medicaid-enrolled facility hosting the client. |

| Facility/Transmission Fee | Federally Qualified Health Centers & Rural Health Clinics Telehealth transmission cost related to non-core services will be the lower of: |

| Managed Care | Managed Care Telehealth transmission is covered as a part of the behavioral health benefits package. |

| Policy | Asynchronous service is included in the definition for telehealth in Nebraska statutes. |
| Source: NE Rev. Statute, 71-8503(3). |

| Store-and-Forward | Nebraska Medicaid will reimburse for tele-radiology when it meets the American College of Radiology standards for tele-radiology. There is no other reference to reimbursing for other specialties. |
## Medicaid Telehealth Reimbursement

### Remote Patient Monitoring

Medicaid will reimburse for telemonitoring when all of the following requirements are met:

- Telemonitoring is covered only when the services are from the originating site;
- The client is cognitively capable to operate the equipment or has a willing and able person to assess in the transmission of electronic data;
- The originating site has space for all program equipment and full transmission capability;
- The provider maintains a client's record supporting the medical necessity of the service.

Paid at daily per diem-rate and includes:

- Review and interpretation of client data;
- Equipment and all supplies, accessories, and services necessary for proper functioning and use of equipment;
- Medically necessary visits to the home by a health care practitioner;
- Training on the use of the equipment and completion of necessary records.

No additional or separate payment is allowed.


### Store-and-Forward

No reference found.

### Geographic Limits

No reference found.

### Transmission Fee

No reference found.

### Policy

No reference found.

### Conditions

No reference found.

### Provider Limitations

No reference found.
No reimbursement for telephone. Follow-up calls after the initial evaluation are included in the cost of the evaluation. Reimbursement may be made for telephone consultations with another physician if the name of the consulting physician is indicated on or in the claim.


### Consent

Written or email consent required before initial service delivery. Must include this information:

- A list of alternative care options, including in-person services;
- All existing laws and protections including: confidentiality protections, patient access to all medical information from the consult, and dissemination of client identifiable information;
- Whether the telehealth consultation will be recorded;
- Patient shall be informed of all parties present at both ends of the consult, and the patient may exclude anyone from either site;
- For telehealth behavioral health services, a safety plan must be developed;
- Special rules apply for a child who is receiving telehealth behavioral health services;
- Written consent will become part of the client’s medical record and a copy must be provided to the client or authorized representative; and
- If the client is a child or otherwise unable to sign the consent form, the client’s legally authorized representative shall provide the consent.

Sample patient consent form available in Manual Appendix.

**Source:** NE Admin. Code Title 471 Sec. 1-006.05, Ch. 1, Manual Letter #52-2016. (Accessed Sep. 2018).

Written patient consent is required prior to an initial telehealth consultation. If the patient is a minor, incapacitated, or mentally incompetent such that they are unable to sign the written statement, written consent must be obtained from the patient’s legally authorized representative. Consent is not required in emergency situations.

**Source:** NE Revised Statutes Sec. 71-8505 (Accessed Sep. 2018).

### Out-of-State Providers

Out-of-State Telehealth Services are covered:

- When the distant site is located in another state and the originating site is located in Nebraska; or
- When the Nebraska client is located at an originating site in another state, whether or not the provider’s distant site is located in or out of Nebraska.

NE Medicaid does provide an outpatient cardiac rehabilitation program consisting of physical exercise or conditioning and concurrent telemetric monitoring are considered a valuable therapeutic modality. When a program is provided by a hospital to its outpatients, the service is covered as an outpatient service.

**Source:** NE Admin. Code Title 471, Sec. 10-005.19, Ch. 10, Manual Letter 48-95. (Accessed Sep., 2018).

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth means the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care provider in the diagnosis or treatment of a patient. Telehealth includes services originating from a patient’s home or any other location where such patient is located, asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to or retrieved by a health care provider at another site for medical evaluation, and telemonitoring.</td>
</tr>
<tr>
<td>Telemonitoring means the remote monitoring of a patient’s vital signs, biometric data, or subjective data by a monitoring device which transmits such data electronically to a health care provider for analysis and storage.</td>
</tr>
</tbody>
</table>

**Source:** NE Revised Statutes. Sec. 44-312(1). (Accessed Sep. 2018).

<table>
<thead>
<tr>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private payers and self-funded employee benefit plans must provide, upon the request of a policyholder, certificate holder, or health care provider, a description of the telehealth and telemonitoring services covered under the relevant policy, certificate, contract, or plan. The description must include:</td>
</tr>
<tr>
<td>• Description of services in telehealth and telemonitoring (including any coverage for transmission costs);</td>
</tr>
<tr>
<td>• Exclusions or limitations (including limitation on transmission costs);</td>
</tr>
<tr>
<td>• Requirements for licensing status;</td>
</tr>
<tr>
<td>• Requirements for signed written consent.</td>
</tr>
</tbody>
</table>

**Source:** NE Revised Statute, Sec. 44-312. (Accessed Sep. 2018).

<table>
<thead>
<tr>
<th>Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Parity</td>
</tr>
<tr>
<td>Private payers and self-funded employee benefit plans are prohibited from excluding a service from coverage solely because the service is delivered through telehealth and is not provided through in-person consultation or contact between a licensed health care provider and a patient. This does not apply to policies, certificates, contracts, or plans that provide coverage for a specified disease or other limited-benefit coverage.</td>
</tr>
</tbody>
</table>

**Source:** NE Revised Statutes, Sec. 44-7,107. (Accessed Sep. 2018).

<table>
<thead>
<tr>
<th>Payment Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No explicit payment parity.</td>
</tr>
<tr>
<td>Professional Regulation/Health &amp; Safety</td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>Definitions</strong></td>
</tr>
<tr>
<td><em>Telehealth</em> means the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a credential holder in the diagnosis or treatment of a patient. Telehealth includes services originating from a patient’s home or any other location where such patient is located, asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to or retrieved by a credential holder at another site for medical evaluation, and telemonitoring.*</td>
</tr>
<tr>
<td><em>Source: NE Revised Statutes Sec. 38-120.01. (Accessed Sep. 2018).</em></td>
</tr>
<tr>
<td><em>Telemonitoring</em> means the remote monitoring of a patient’s vital signs, biometric data, or subjective data by a monitoring device which transmits such data electronically to a credential holder for analysis and storage.*</td>
</tr>
<tr>
<td><em>Source: NE Revised Statutes Sec. 38-120.02. (Accessed Sep. 2018).</em></td>
</tr>
<tr>
<td><strong>Consent</strong></td>
</tr>
<tr>
<td><em>No reference found.</em></td>
</tr>
<tr>
<td><strong>Online Prescribing</strong></td>
</tr>
<tr>
<td><em>A physician or physician assistant may establish a provider-patient relationship through telehealth and may prescribe while using telehealth.</em></td>
</tr>
<tr>
<td><em>Source: NE Revised Statute 38-2063. (Accessed Sep. 2018).</em></td>
</tr>
<tr>
<td><strong>Cross-State Licensing</strong></td>
</tr>
<tr>
<td><em>Member of the Interstate Medical Licensure Compact.</em></td>
</tr>
<tr>
<td><em>Source: The IMLC. Interstate Medical Licensure Compact. (Accessed Sep. 2018).</em></td>
</tr>
<tr>
<td><em>Member of the Psychology Interjurisdictional Compact of the Association of State and Provincial Psychology Boards.</em></td>
</tr>
<tr>
<td><em>Member of the Nurse Licensure Compact.</em></td>
</tr>
<tr>
<td><em>Member of the Physical Therapy Compact.</em></td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
</tr>
<tr>
<td><em>A stroke system of care task force shall recommend eligible essential health care services for acute stroke care provided through telehealth.</em></td>
</tr>
<tr>
<td><em>Source: NE Revised Statutes 71-4209. (Accessed Sep. 2018).</em></td>
</tr>
</tbody>
</table>
Summary

Nevada Medicaid and the Nevada Check Up (NCU) program reimburses for live video and store-and-forward services under specific conditions. There is no reimbursement for remote patient monitoring.

Definitions

"Telehealth is the use of a telecommunications system to substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other medical services."

"Telehealth" is defined as the delivery of service from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile, or electronic mail.


Live Video Policy

Nevada Medicaid and Nevada Check Up program will reimburse for live video, as long as services have parity with face-to-face services and health care professionals follow Medicaid’s policies for specific services they are providing, as well as practice standards established by licensing agencies. Reimbursement must satisfy federal requirements for efficiency, economy, and quality of care.

Telehealth services follow the same prior authorization requirements as services provided in-person. Utilization of telehealth services does not require prior authorization. However, individual services may require prior authorization, whether delivered in-person or by telehealth.

End Stage Renal Disease requires at least one in-person visit, indicated in the medical records. Interactive audio/video telecommunications systems may be used for providing additional visits.

Medicaid Managed Care plans must include coverage for services provided through telehealth to the same extent as though provided in-person or by other means.

Medicaid Managed Care plans shall not:

- Require an enrollee to establish an in-person relationship with a provider or provide any additional consent to or reason for obtaining services through telehealth;
- Require a provider of health care to demonstrate that it is necessary to provide services to an enrollee through telehealth or receive any additional type of certification or license;
- Refuse to provide services through telehealth because the distant site or originating site; or
- Require covered services to be provided through telehealth as a condition of providing coverage for such services.

A Medicaid Managed Care plan may not require an enrollee to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in-person.

Medicaid Managed Care plans are not required to:

- Ensure that covered services are available to an enrollee through telehealth at a particular originating site;
- Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or
- Enter into a contract with any provider of health care or cover any service if the insurer is not otherwise required by law to do so.


Telehealth services are covered in:

- Physician Office Services
- Podiatry
- Community Paramedicine Services
- Medical Nutrition Therapy


Services NOT Covered:

- Basic skills training and peer-to-peer services provided by a Qualified Behavioral Assistant
- Personal care services provided by a Personal Care Attendant
- Home Health Services provided by a RN, occupational therapist, physical therapist, speech therapist, respiratory therapist, dietician or Home Health Aide
- Private Duty Nursing services provided by a RN

Medicaid Telehealth Reimbursement

Telehealth may be used by any Nevada Medicaid and Nevada Check Up provider working within their scope of practice.


A distant site provider must be an enrolled Medicaid provider.

Licensed Clinical Psychologists, Licensed Clinical Social Workers and clinical staff may bill and receive reimbursement for psychotherapy, but not for medical evaluation and management services.


Eligible Providers

Eligible Providers

Eligible Sites

Eligible sites:

- Office of provider
- Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)
- Federally Qualified Health Center (FQHC)
- Hospital
- End Stage Renal Disease (ESRD) Facility
- Skilled Nursing Facility (SNF)
- Community Mental Health Centers (CMHC)
- Indian Health Services/Tribal Organization/Urban Indian Organization
- School-Based Health Centers
- Schools
- Family Planning Clinics
- Public Health Clinics
- Comprehensive Outpatient Rehabilitation Facilities
- Community Health Clinics (State Health Division)
- Special Children’s Clinics
- Human Immunodeficiency Virus (HIV) Clinics
- Therapy offices
- Chiropractic offices
- Emergency Medical Services (EMS) performing Community Paramedic Services
- Recipient’s smart phone (no facility fee)
- Recipient’s home computer (no facility fee)


Geographic Limits

A Medicaid Managed Care Organization may not refuse to provide coverage of telehealth services because of the distant or originating site.

Originating site is qualified to receive a facility fee if they are an enrolled Medicaid provider. If a patient is receiving telehealth services at a site not enrolled in Medicaid, the originating site is not eligible to receive a facility fee.

Facilities that are eligible for encounter reimbursement may bill for an encounter in lieu of an originating site facility fee, if the distant site is for ancillary services.


A facility fee is not billable if the telecommunication system used is a recipient’s smart phone or home computer.


Some provider types that may bill for an originating site facility fee include:

- Some Special Clinic provider types
- Some Applied Behavior Analysis provider types
- Therapists
- Chiropractors
- Providers at End-Stage Renal Disease Facilities


Sites eligible for an originating site facility fee include:

- Office of provider
- Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)
- Federally Qualified Health Center (FQHC)
- Hospital
- End Stage Renal Disease (ESRD) Facility
- Skilled Nursing Facility (SNF)
- Community Mental Health Centers (CMHC)
- Indian Health Services/Tribal Organization/Urban Indian Organization
- School-Based Health Centers
- Schools
- Family Planning Clinics
- Public Health Clinics
- Comprehensive Outpatient Rehabilitation Facilities
- Community Health Clinics (State Health Division)
- Special Children’s Clinics
- Human Immunodeficiency Virus (HIV) Clinics
- Therapy offices
- Chiropractic offices
- Emergency Medical Services (EMS) performing Community Paramedic Services


Reimbursement is available for services delivered via asynchronous telehealth. Photographs must be specific to the patient’s condition and adequate for rendering or confirming a diagnosis or a treatment plan.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Store-and-Forward</strong></td>
</tr>
<tr>
<td>Eligible Services/Specialties</td>
</tr>
<tr>
<td>Geographic Limits</td>
</tr>
<tr>
<td>Transmission Fee</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Policy</td>
</tr>
<tr>
<td>Conditions</td>
</tr>
<tr>
<td>Provider Limitations</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td>Remote Patient Monitoring</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
### Definitions

“Telehealth” means the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail.

**Source:** NV Revised Statutes Sec. 616C.730(d) & Sec. 629.515(4)(c). (Accessed Sep. 2018).

### Requirements

Insurers shall not:

- Require an enrollee to establish an in-person relationship with a provider or provide any additional consent to or reason for obtaining services through telehealth;
- Require a provider of health care to demonstrate that it is necessary to provide services to an enrollee through telehealth or receive any additional type of certification or license;
- Refuse to provide services through telehealth because the distant site or originating site; or
- Require covered services to be provided through telehealth as a condition of providing coverage for such services.

A policy may not require an enrollee to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in-person.

Insurers are not required to:

- Ensure that covered services are available to an enrollee through telehealth at a particular originating site;
- Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or
- Enter into a contract with any provider of health care or cover any service if the insurer is not otherwise required by law to do so.

These requirements also apply to state employee health insurance policies.

Prepaid limited health service organizations are also subject to these requirements to the extent reasonably acceptable.

**Source:** NV Revised Statute Sec. 689A.0463; Sec. 689B.0369; Sec. 689C.195; Sec. 616C.730; Sec. 695A.265; Sec. 695B.1904; Sec. 695C.1708; Sec. 695D.216; Sec. 695F.090(i); & Sec. 695G.162. (Accessed Sep. 2018).

When making any determination concerning the availability and accessibility of the services of any network health plan, the Commissioner of Insurance shall consider services that may be provided through telehealth.

**Source:** NV Revised Statues Sec. 687B.490(7). (Accessed Sep. 2018).

### Parity

Every health plan policy issued must include coverage for services provided through telehealth to the same extent as though provided in-person or by other means. This also applies to state employee health insurance policies.

This also applies to prepaid limited health service organizations to the extent reasonably acceptable.

**Source:** NV Revised Statute Sec. 689A.0463(1); Sec. 689B.0369(1); Sec. 689C.195(1); Sec. 616C.730(1); Sec. 695A.265(1); Sec. 695B.1904(1); Sec. 695C.1708(1); Sec. 695D.216(1); Sec. 695F.090(i); & Sec. 695G.162(1). (Accessed Sep. 2018).
<table>
<thead>
<tr>
<th>Private Payer Laws</th>
<th>Parity</th>
<th>Payment Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No explicit payment parity.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth means the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Regulation/Health &amp; Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>A provider of health care who is located at a distant site and uses telehealth to direct or manage the care or render a diagnosis of a patient who is located in Nevada or write a treatment order or prescription for such a patient must comply with all state and federal laws that would apply if the provider was located within the state including holding a valid license or certificate to practice in Nevada.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Online Prescribing</th>
</tr>
</thead>
<tbody>
<tr>
<td>A physician-patient relationship, required to fill prescriptions that call for schedule II, III, or IV controlled substances, may be established in-person, electronically, telephonically, or by fiber optics, including without limitation via telehealth within or outside Nevada or the United States within 6 months preceding the date the prescription is issued.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Online Prescribing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a practitioner prescribes a schedule II, III, or IV controlled substance for the treatment of pain, they may not prescribe more than one additional prescription that increases the dose unless they meet with the patient in-person or through telehealth to reevaluate the treatment plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Online Prescribing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before prescribing a schedule II, III, or IV controlled substance to continue the treatment of pain of a patient who has used the controlled substance for 90 consecutive days or more, a practitioner must meet with the patient in-person or through telehealth to review the treatment plan and determine whether continuation of treatment using the controlled substance is medically appropriate, in addition to other requirements.</td>
</tr>
</tbody>
</table>
### Online Prescribing

An advanced practice registered nurse authorized to prescribe controlled substances may do so electronically, telephonically or by fiber optics, including telehealth, from within or outside Nevada or the United States.


### Cross-State Licensing

A practitioner must hold a valid Nevada License or certificate to practice his or her profession, including a special purpose license before providing services via telehealth unless he or she is a provider of health care services who is providing services within the scope of his or her employment by or pursuant to a contract entered into with an urban Indian organization.

**Source**: NV Revised Statutes Sec. 629.515(1) (Accessed Sep. 2018).

A physician licensed in another state may be issued a special purpose license to deliver services electronically, telephonically or by fiber optics, including, without limitation, through telehealth, from within or outside Nevada or the United States.


**Member of the Interstate Medical Licensure Compact.**


**Member of the Psychology Interjurisdictional Compact of the Association of State and Provincial Psychology Boards.**


### Miscellaneous

The Board of Medicine is required to adopt regulations regarding a physician assistant’s use of equipment that transfers information concerning the medical condition of a patient electronically, telephonically or by fiber optics, including, without limitation, through telehealth, from within or outside Nevada or the United States.


A hospital may grant staff privileges to a provider of health care who is at another location for the purpose of providing services through telehealth.


The NV Board of Pharmacy is required to adopt regulations regarding the practice of telepharmacy.


There are specific standards for telepractice for speech-language pathology and audiology.

**Source**: NV Revised Statutes Sec. 637B.244. (Accessed Sep. 2018).

### Professional Board Telehealth-Specific Regulations

New Hampshire Medicaid follows the Center for Medicare and Medicaid Services requirements and Federal regulations for the use of telehealth and telemedicine. Reimbursement is available for live video under some circumstances. There is no reimbursement for store-and-forward or remote patient monitoring services, based on Medicare restrictions.

“Telehealth services” and the term “telemedicine” shall comply with 42 C.F.R. section 410.78 and the Centers for Medicare and Medicaid Services requirements.


Limited reimbursement for some live video services. NH Medicaid follows the reimbursement policies of Medicare with the exception of CMS’ geographic requirement. However, CMS’ restrictions on modality, originating site, services, and distance providers still apply.

A Medicaid program is not prohibited from providing coverage for only those services that are medically necessary and subject to all other terms and conditions of the coverage.


New Hampshire Medicaid complies with the Centers for Medicare and Medicaid Service requirements for telehealth. See Medicare’s list of CPT codes for a full list of services reimbursable under New Hampshire Medicaid.

Providers who may receive reimbursement (based on Medicare list):

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Nurse-midwife
- Clinical psychologist and clinical social worker (may not seek payment for medical evaluation and management services)
- Registered dietician or nutrition professional
- Nurse anesthetist


Authorized originating sites are (based on Medicare list):

- The offices of physicians or practitioners
- 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) and
- Community Mental Health Centers (CMHCs)


New Hampshire Medicaid does not follow 42 CFR 410.78(b)(4), listing geographic and site restrictions on originating sites. No other reference found.


New Hampshire Medicaid complies with the Centers for Medicare and Medicaid Service requirements for telehealth. Based on the Medicare requirements, originating sites are eligible for a facility fee.


There is no reimbursement for store-and-forward as telehealth must use interactive telecommunications systems permitting two-way, real-time interactive communication.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Eligible Services/Specialties</th>
<th>No reference found.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Geographic Limits</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Transmission Fee</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
| Remote Patient Monitoring        | Policy                       | There is no reimbursement for remote patient monitoring as telehealth must use interactive telecommunications systems permitting two-way, real-time interactive communication.  
|                                  | Conditions                   | No reference found. |
|                                  | Provider Limitations         | No reference found. |
### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Remote Patient Monitoring</th>
<th>Other Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email / Phone / Fax</th>
<th>Other Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reimbursement for email.</td>
<td>No reference found.</td>
</tr>
<tr>
<td>No reimbursement for telephone.</td>
<td>No reference found.</td>
</tr>
<tr>
<td>No reimbursement for FAX.</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Consent</th>
<th>Other Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental consent is required when delivering medical services reimbursed by Medicaid to children in public schools.</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

**Source:** NH Revised Statutes 167:3-k (Accessed Sep. 2018).

<table>
<thead>
<tr>
<th>Out of State Providers</th>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td>Parental consent is required when delivering medical services reimbursed by Medicaid to children in public schools.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous</th>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>As of December 1, 2013 New Hampshire Medicaid transitioned to a managed care model of administration under three health plans. These plans each have their own telehealth coverage policy.</td>
<td>Parental consent is required when delivering medical services reimbursed by Medicaid to children in public schools.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Private Payer Laws</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Telemedicine, as it pertains to the delivery of health care services, means the use of audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include the use of audio-only telephone or facsimile.”</td>
<td>As of December 1, 2013 New Hampshire Medicaid transitioned to a managed care model of administration under three health plans. These plans each have their own telehealth coverage policy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Private Payer Laws</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requirements</strong></td>
</tr>
<tr>
<td>Insurers are not prohibited from providing coverage for only those services that are medically necessary and subject to the terms and conditions of the covered person’s policy.</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
</tr>
<tr>
<td><strong>Service Parity</strong></td>
</tr>
<tr>
<td>Insurers may not deny coverage for services on the sole basis that the coverage is provided through telemedicine if the health care service would be covered if it were provided through in-person consultation between the covered person and a health care provider.</td>
</tr>
<tr>
<td><strong>Payment Parity</strong></td>
</tr>
<tr>
<td>No explicit payment parity.</td>
</tr>
<tr>
<td><strong>Professional Regulation/Health &amp; Safety</strong></td>
</tr>
<tr>
<td><strong>Definitions</strong></td>
</tr>
<tr>
<td>Telemedicine means the use of audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. Telemedicine shall not include the use of audio-only telephone or facsimile.</td>
</tr>
<tr>
<td><strong>Consent</strong></td>
</tr>
<tr>
<td>Patient consent is required prior to forwarding medical records to the patient’s primary care or treating provider, if appropriate.</td>
</tr>
<tr>
<td><strong>Source:</strong> NH Revised Statutes Annotated, 329:1-d-V(c) (Accessed Sep. 2018).</td>
</tr>
</tbody>
</table>
A physician-patient relationship requires an in-person exam that may take place via a face-to-face two-way real-time interactive communication. Prescribing drugs to individuals without a physician-patient relationship is prohibited, except under the following conditions:

- Writing admission orders for a newly hospitalized patient;
- A patient of another provider for whom the prescriber is taking call;
- A prescription for a patient who has been examined by a physician assistant, nurse practitioner, or other licensed practitioner;
- Medication on a short-term basis for a new patient prior to the patient’s first appointment;
- When providing limited treatment to a family member in accordance with the American Medical Association Code of Medical Ethics.


It is unlawful to prescribe through telemedicine a controlled drug classified in schedule II through IV.


A prescription of a non-opioid controlled drug classified in schedule II through IV via telemedicine shall be limited to certain practitioners who are treating a patient with whom the prescriber has an in-person practitioner-patient relationship, for purposes of monitoring or follow-up care, and who are treating patients at a state designated community mental health center or a Substance Abuse and Mental Health Services Administration-certified state opioid treatment program, and shall require an initial in-person exam by a practitioner licensed to prescribe the drug.

A prescription of an opioid controlled drug classified in schedule II through IV via telemedicine shall be limited to prescribers who are treating patients at a Substance Abuse and Mental Health Services Administration-certified state opioid treatment program, and shall require an initial in-person exam by a practitioner licensed to prescribe the drug.

Subsequent in-person exams must be by a practitioner licensed to prescribe the drug at intervals appropriate for the patient, medical condition, and drug, but not less than annually.

Source: NH Revised Statutes Annotated 318-B:2(XVI).

Member of the Nurse Licensure Compact.


Member of the Physical Therapy Compact.


Member of the Interstate Medical Licensure Compact.


An out-of-state physician providing services via telemedicine or teleradiology shall be deemed to be in the practice of medicine and required to be licensed in New Hampshire. This does not apply to physicians who provide consultation services.


A committee has been established to study health care reimbursement for telemedicine and telehealth in New Hampshire. The committee must report its findings by Nov. 1, 2018.


A board of medical imaging professionals and radiation therapists shall adopt rules relative to standards of care for the practice of telemedicine or telehealth.

**Medicaid Program:** New Jersey Medicaid  
**Program Administrator:** New Jersey Dept. of Human Services  
**Regional Telehealth Resource Center:** Northeast Telehealth Resource Center & Mid-Atlantic Telehealth Resource Center  
**Northeast Telehealth Resource Center Covers the States of:** Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island & Vermont  
**Mid-Atlantic Telehealth Resource Center Covers the States of:** Delaware, Kentucky, Maryland, New Jersey, North Carolina, Pennsylvania, Virginia, West Virginia, and Washington DC  

**Summary**

New Jersey Medicaid reimburses for live video and remote patient monitoring under certain circumstances. Store-and-forward is not explicitly included in reimbursement; however, it could be covered within the definition of telemedicine. Individual Medicare managed care plans may have their own individual policies regarding telehealth and telemedicine.

**Definitions**

**Telemedicine** means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care provider who is located at a distant site and a patient who is located at an originating site, either with or without the assistance of an intervening health care provider. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text or facsimile transmission.

**Telehealth** means the use of information and communications technologies, including telephones, remote patient monitoring devices or other electronic means to support clinical health care, provider consultation, patient and professional health related education, public health, health administration and other services.


**Live Video**

**Policy**

NJ Medicaid must provide coverage and payment for telemedicine or telehealth delivered services on the same basis as when the services are delivered through in-person contact and consultation in NJ. The reimbursement rate may not exceed the rate of in-person contact. Reimbursement is provided either to the individual practitioner who delivered the reimbursable services, or to the agency, facility, or organization that employs the individual practitioner, as appropriate.

NJ Medicaid and NJ FamilyCare programs may limit coverage to services that are delivered by participating health care providers, but may not charge a deductible, copayment, or coinsurance for a health care service, delivered through telemedicine or telehealth, in an amount that exceeds the deductible, copayment, or coinsurance amount that is applicable to an in-person consultation.

The commissioner will apply for a State Plan amendment as necessary to implement this.

### Medicaid Telehealth Reimbursement

#### Eligible Services / Specialties

**Psychiatric Services**

Telepsychiatry may be utilized by mental health clinics and/or hospital providers of outpatient mental health services to meet their physician related requirements including but not limited to intake evaluations, periodic psychiatric evaluations, medication management and/or psychotherapy sessions for clients of any age.

Before any telepsychiatry services can be provided, each participating program must establish related policies and procedures.

Mental health clinics and hospital providers are limited to billing for services permitted by the Division of Medical Assistance and Health Services.


For the Screening and Outreach Program, designed to provide clinical assessment and crisis stabilization services to consumers, a psychiatric evaluation may be completed through the use of telepsychiatry, provided that the screening service has a Division-approved plan setting forth its policies and procedures for providing a psychiatric assessment via telepsychiatry that meets certain criteria (see regulation).

*Source: NJAC 10:31-2.3. (Accessed Sep. 2018).*

#### Eligible Providers

- Psychiatrist
- Psychiatric Advanced Practice Nurse


#### Eligible Sites

A patient may receive services at the mental health clinic or outpatient hospital program.


#### Geographic Limits

No reference found.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Live Video</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Facility/Transmission Fee</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Policy</strong></td>
<td>Insurers and NJ Medicaid must provide reimbursement for telemedicine or telehealth on the same basis as, and at a provider reimbursement rate that does not exceed the provider reimbursement rate that is applicable, when services are delivered through in-person contact and consultation. Store-and-forward is not explicitly included, but could fit into these definitions. <strong>Source</strong>: NJ Statute C.30:4D-6k. (Accessed Sep. 2018).</td>
</tr>
<tr>
<td><strong>Store-and-Forward</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Eligible Services/Specialties</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Geographic Limits</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Transmission fee</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Policy</strong></td>
<td></td>
</tr>
<tr>
<td>Insurers and NJ Medicaid must provide reimbursement for telemedicine or telehealth on the same basis as, and at a provider reimbursement rate that does not exceed the provider reimbursement rate that is applicable, when services are delivered through in-person contact and consultation. Remote patient monitoring is included within definition of telehealth.</td>
<td></td>
</tr>
<tr>
<td><strong>Conditions</strong></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Limitations</strong></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td><strong>Other Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td><strong>Email / Phone / Fax</strong></td>
<td></td>
</tr>
<tr>
<td>Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text or facsimile transmission.</td>
<td></td>
</tr>
<tr>
<td>Telehealth means the use of information and communications technologies, including telephones.</td>
<td></td>
</tr>
<tr>
<td><strong>Consent</strong></td>
<td></td>
</tr>
<tr>
<td>Informed consent is required for telepsychiatry. If a patient chooses not to participate in telepsychiatry, they must be made aware of other face-to-face options and services. If they choose to participate, they must be informed of the location of the psychiatrist/advanced practice nurse providing the telepsychiatry service.</td>
<td></td>
</tr>
</tbody>
</table>
### Medicaid Telehealth Reimbursement

**Out of State Providers**

A psychiatrist or psychiatric APN may be off-site, but must be licensed in the State of New Jersey.


**New Jersey’s Medicaid Program is managed care, with five participating health plans. The health plans may or may not have their own telehealth related policies.**


### Psychiatric Services

If a physical evaluation is required as part of a psychiatric assessment, the hosting provider must have a registered nurse available to share the results of the physical evaluation.

NJ Medicaid does not reimburse for any costs associated with the provision of telepsychiatry services.

Additional requirements are listed in the telepsychiatry memo.


---

### Definitions

**Telemedicine** means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care provider who is located at a distant site and a patient who is located at an originating site, either with or without the assistance of an intervening health care provider. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text or facsimile transmission.

**Telehealth** means the use of information and communications technologies, including telephones, remote patient monitoring devices or other electronic means to support clinical health care, provider consultation, patient and professional health related education, public health, health administration and other services.


### Requirements

A carrier that offers a health benefits plan shall provide coverage and payment for health care services delivered to a covered person through telemedicine or telehealth, on the same basis as, and at a provider reimbursement rate that does not exceed the provider reimbursement rate that is applicable, when the services are delivered through in-person contact and consultation. Reimbursement payments under this section may be provided either to the individual practitioner who delivered the reimbursable services, or to the agency, facility, or organization that employs the individual practitioner who delivered the reimbursable services, as appropriate.

A carrier may limit coverage to services that are delivered by health care providers in the health benefits plan’s network, but may not charge any deductible, copayment, or coinsurance for a health care service, delivered through telemedicine or telehealth, in an amount that exceeds the deductible, copayment, or coinsurance amount that is applicable to an in-person consultation.

Insurers must provide coverage and payment for health services delivered through telemedicine or telehealth on the same basis as when the services are delivered through in-person contact and consultation.

A health care plan is not prohibited from providing coverage only for services that are medically necessary, subject to the terms and conditions of the plan.

A health care plan may not require a covered person to use telemedicine or telehealth in lieu of receiving an in-person service from an in-network provider.


The above also applies to contracts purchased by the State Health Benefits Commission and the School Employees’ Health Benefits Commission.


Reimbursement must be made for health care services delivered through telemedicine or telehealth, on the same basis as, and at a provider reimbursement rate that does not exceed the provider reimbursement rate for in-person contact.

A health care plan may limit coverage to services that are delivered by health care providers in a plan’s network, but may not charge any deductible, copayment, or coinsurance for a health care service in an amount that exceeds the deductible, copayment, or coinsurance amount that is applicable to an in-person consultation.


The above also applies to contracts purchased by the State Health Benefits Commission and the School Employees’ Health Benefits Commission.


Telemedicine means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care provider who is located at a distant site and a patient who is located at an originating site, either with or without the assistance of an intervening health care provider. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text or facsimile transmission.

Telehealth means the use of information and communications technologies, including telephones, remote patient monitoring devices or other electronic means to support clinical health care, provider consultation, patient and professional health related education, public health, health administration and other services.


With a patient’s oral, written, or digital consent, the patient’s medical information may be forwarded directly to the patient’s primary care provider or health care provider of record, or, upon request by the patient, to other health care providers.

Online Prescribing

The prescription of Schedule II controlled substances through telemedicine or telehealth is authorized only after an initial in-person examination, and subsequent in-person visit with the patient is required every three months for the duration of prescription. Does not apply when prescribing stimulant for use by a minor under the age of 18 provided the health care provider is using live video when treating the patient and the health care provider has obtained written consent for the waiver form the minor patient’s parent or guardian.


A provider patient relationship shall include:

• Properly identifying the patient, using at minimum the patient’s name, date of birth, phone number, and address.
• Disclosing and validating the provider’s identity and credentials, such as license, title, specialty, and board certifications.
• Review of patient’s medical records, prior to initiating contact.
• Determining whether the provider will be able to meet the standard of care, prior to initiating contact.

See statute for exceptions.


Member of the Physical Therapy Compact.


Must be licensed in the State of New Jersey. Subject to New Jersey jurisdiction if either the patient or the provider is located in NJ at the time services are provided.


Each telehealth or telemedicine organization operating in the State shall annually register with the Department of Health and submit an annual report. See statute for details.


Six months after the effective date, a Telemedicine and Telehealth Review Commission will be established which will review reports and make recommendations.


Telemedicine practice standards indicate live video is allowed. Store-and-forward allowed when used in combination with two-way audio without video, if after assessing and reviewing the patient’s medical records, the provider determines that the provider is able to meet the same standard of care as if the health care service was being provided in-person.

See statute for additional telemedicine/telehealth practice standards.


A mental health screener, screening service, or screening psychiatrist subject to C.30:4-27.1:

• Shall not be required to obtain a separate authorization in order to engage in telemedicine or telehealth for mental health screening purposes; and
• Shall not be required to request and obtain a waiver from existing regulations, prior to engaging in telemedicine or telehealth.

**Medicaid Program:** New Mexico Medicaid

**Program Administrator:** New Mexico Human Services Dept., Medical Assistance Division (MAD)

**Regional Telehealth Resource Center:** Southwest Telehealth Resource Center

**Covers the States of:** Arizona, Colorado, Nevada, New Mexico & Utah

www.southwesttrc.org

<table>
<thead>
<tr>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico Medicaid reimburses for live video telehealth at the same rate as when services are provided in-person as well as store-and-forward. There is no reference to remote patient monitoring.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico Medicaid will reimburse for live video at the same rate as when the services are furnished without the use of a telecommunication system.</td>
</tr>
</tbody>
</table>


**Telemedicine is also covered by NM Managed Care.**


<table>
<thead>
<tr>
<th>Managed Care Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>The benefits package includes telemedicine services.</td>
</tr>
</tbody>
</table>

**Source:** NM Admin Code Sec. 8.309.4.16 & 8.308.9.18. (Accessed Sept. 2018).

Provision of telemedicine services does not require that a certified Medicaid healthcare provider be physically present with the patient at the originating site unless the telemedicine consultant at the distant site deems it necessary.

### Medicaid Telehealth Reimbursement

#### Live Video

- **Eligible Services / Specialties**
  - No reference found.

- **Eligible Providers**
  - No reference found.

- **Eligible Sites**
  - School-based services provided via telemedicine are covered.

  - An interactive telehealth communication system must include both interactive audio and video, and be delivered on a real-time basis at both the originating and distant sites. The originating site can be any medically warranted site. Coverage for services rendered through telemedicine shall be determined in a manner consistent with Medicaid coverage for health care services provided through in-person consultation.

- **Geographic Limits**
  - No reference found.

#### Facility / Transmission Fee

- Reimbursement is made to the originating site for an interactive telehealth system fee at the lesser of the following:
  - Provider’s billed charge;
  - Maximum allowed by MAD for the specific service or procedure.

  - A telemedicine originating-site communication fee is also covered if the eligible recipient was present at and participated in the telemedicine visit at the originating site.
    - **Source:** NM Administrative Code 8.310.2.12 (M(4)). (Accessed Sept. 2018).

  - An originating site facility fee is not payable if telemedicine is used to connect an employee or staff member of a facility to the eligible recipient being seen at the same facility.

#### Indian Health Services

- A telemedicine facility fee is paid. Both the originating and distant sites may be IHS or tribal facilities at two different locations, or a distant site can be under contract to the IHS or tribal facility and would qualify to be an enrolled provider.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Store-and-Forward Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New Mexico Medicaid does reimburse for store-and-forward. To be eligible, the service must be provided through the transfer of digital images, sounds, or previously recorded video from one location to another. It does not need to occur in real time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Eligible Services/Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Geographic Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Transmission Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reimbursement is made to the originating site for an interactive telehealth system fee at the lesser of the following:</td>
</tr>
<tr>
<td></td>
<td>- Provider’s billed charge;</td>
</tr>
<tr>
<td></td>
<td>- Maximum allowed by MAD for the specific service or procedure.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No reference found.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td>No reference found.</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Remote Patient Monitoring</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Provider Limitations</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Other Restrictions</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Email / Phone / Fax</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Consent</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Out of State Providers</td>
<td>When the originating site is in New Mexico and the distant site is outside New Mexico, the distant-site provider at the distant site must be licensed in New Mexico for telemedicine, or meet federal requirements for Indian Health Service or tribal contract facilities.</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>MCOs must:</td>
</tr>
<tr>
<td></td>
<td>• Promote and employ broad-based utilization of statewide access to Health Insurance Portability and Accountability Act (HIPAA)-compliant telemedicine service systems including, but not limited to, access to text telephones or teletype (TTYs) and 711 telecommunication relay services;</td>
</tr>
<tr>
<td></td>
<td>• Follow state guidelines for telemedicine equipment or connectivity;</td>
</tr>
</tbody>
</table>
Medicaid Telehealth Reimbursement

### Miscellaneous

- Follow accepted HIPAA and 42 CFR part two regulations that affect telemedicine transmission, including but not limited to staff and contract provider training, room setup, security of transmission lines, etc; the MCO shall have and implement policies and procedures that follow all federal and state security and procedure guidelines;
- Identify, develop, and implement training for accepted telemedicine practices;
- Participate in the needs assessment of the organizational, developmental, and programmatic requirements of telemedicine programs;
- Report to HSD on the telemedicine outcomes of telemedicine projects and submit the telemedicine report; and
- Ensure that telemedicine services meet the following shared values, which are ensuring: competent care with regard to culture and language needs; work sites are distributed across the state, including native American sites for both clinical and educational purposes; and coordination of telemedicine and technical functions at either end of network connection.

The MCO shall participate in project extension for community healthcare outcomes (ECHO), in accordance with state prescribed requirements and standards, and shall:

- Work collaboratively with HSD, the university of New Mexico, and providers on project ECHO;
- Identify high needs, high cost members who may benefit from project ECHO participation;
- Identify its PCPs who serve high needs, high cost members to participate in project ECHO;
- Assist project ECHO with engaging its MCO PCPs in project ECHO's center for Medicare and Medicaid innovation (CMMI) grant project;
- Reimburse primary care clinics for participating in the project ECHO model;
- Reimburse “intensivist” teams;
- Provide claims data to HSD to support the evaluation of project ECHO;
- Appoint a centralized liaison to obtain prior authorization approvals related to project ECHO; and
- Track quality of care and outcome measures related to project ECHO.

**Source:** NM Regulation 8.308.9.18.

---

### Definitions

**Telemedicine** means the use of interactive simultaneous audio and video or store-and-forward technology using information and telecommunications technologies by a health care provider to deliver health care services at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the health care diagnosis or treatment of the patient in real time or through the use of store-and-forward technology.


---

### Requirements

An insurer shall allow covered benefits to be provided through telemedicine services. Covered services through telemedicine are determined in a manner consistent with coverage for health care services provided through in-person consultation.

A determination that a service is not covered through the use of telemedicine are subject to review and appeal. Plans cannot require a health care provider to be physically present with the patient at the originating site unless the consulting provider deems it necessary.

Telemedicine services shall be encrypted and conform to state and federal privacy laws.

Private Payer Laws

Parity

An insurer shall allow covered benefits to be provided through telemedicine services.


Payment Parity

No explicit payment parity.

Covered services through telemedicine are determined in a manner consistent with coverage for health care services provided through in-person consultation.


Professional Regulation/Health & Safety

Definitions

Medicine and Surgery
“The practice of medicine across state lines means the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of a patient within this state, by a physician located outside this state, as a result of transmission of individual patient data by electronic, telephonic or other means from within this state, to the physician or the physician’s agent, OR the rendering of treatment to a patient within this state, by a physician located outside this state, as a result of transmission of individual patient data by electronic, telephonic or other means from within this state to the physician or the physician’s agent.”


“Telehealth means the use of electronic information, imaging and communication technologies, including interactive audio, video and data communications as well as store-and-forward technologies, to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data and education.”


Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Board
“Telehealth” means the use of telecommunications and information technologies for the exchange of information from one site to another for the provision of audiology, speech-language pathology or hearing aid dispensing services to an individual from a provider through hardwire or internet connection.


Osteopathic Medicine
“Telemedicine” means the practice of medicine across state lines using electronic communications, information technology or other means between a licensed osteopathic physician out of state and a patient in New Mexico. Telemedicine involves the application of secure videoconferencing or store-and-forward technology to provide or support healthcare delivery by replicating the traditional interaction of the in-person encounters between a provider and a patient.


Consent

Hearing, Speech and Audiology Practitioners
A licensed audiologist, speech-language pathologist or hearing aid dispenser using telecommunication technology to deliver services to a client shall provide notice to the client, guardian, caregiver and multi-disciplinary team as appropriate, including but not limited to the right to refuse telehealth services, options for service delivery and instruction on filing and resolving complaints.

Prescribing, dispensing or administering drugs or medical supplies to a patient when there is no established physician-patient relationship, including prescribing over the internet or via other electronic means that is based solely on an on-line questionnaire is unprofessional conduct, except for:

- Physicians and physician assistants on call for another practitioner, or responsible for another practitioner’s patients in an established clinic or office, or acting as locum tenens where a physician-patient relationship has previously been established and documented in the practitioner’s or clinic’s record;
- Physicians and physician assistants in emergency room or urgent care settings;
- Prescriptions written to prepare a patient for special examination(s) or laboratory testing;
- Prescribing or dispensing for immunization programs;
- The provision of treatment for patients with sexually transmitted diseases when this treatment is conducted in accordance with the expedited partner therapy guidelines and protocol published by the New Mexico department of health; and
- The provision of consultation, recommendation, or treatment during a face-to-face telehealth encounter online, using standard videoconferencing technology, where a medical history and informed consent are obtained and a medical record generated by the practitioner, and a physical examination is:
  - Recorded as appropriate by the practitioner, or a practitioner such as a physician, a physician or anesthesiologist assistant, or an advanced practice nurse, with the results communicated to the telehealth practitioner; or
  - Waived when a physical examination would not normally be part of a typical physical face-to-face encounter with the patient for the specific services being provided.


NM issues telemedicine licenses to providers who hold a full, unrestricted license in another state and has good moral character.

Source: NM Statutes Annotated, 1978 Sec. 61-6-11.1 and 16.10.2.11.

NM Board of Osteopathic Medicine will issue telemedicine license.

Source: NM Statute Chapter 61, Article 10, Sec. 11.1. (Repealed – Effective July 1, 2022).

New Mexico is a member of the Nurse Licensure Compact.


Professional regulation with telehealth specific standards

- Speech Language Pathology, Audiology, and Hearing Aid Dispensing Practice Board


An audiologist, speech-language pathologist or hearing aid dispenser shall not deliver services to a client solely through the use of regular mail, facsimile or electronic mail, although these methods of communication may be used to supplement the face-to-face delivery of services or through the use of telecommunication technology.


New Mexico is also the home of Project ECHO. The project’s mission is to develop the capacity to safely and effectively treat chronic, common, and complex diseases in rural and underserved areas, and to monitor outcomes of this treatment utilizing technology.
### New York

**Medicaid Program:** New York Medicaid  
**Program Administrator:** New York State Dept. of Health  
**Regional Telehealth Resource Center:** Northeast Telehealth Resource Center  
**Covers the States of:** Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island & Vermont  
[www.netrc.org](http://www.netrc.org)

<table>
<thead>
<tr>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York Medicaid offers live video reimbursement and some reimbursement for home health services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
</table>
| Telemedicine is the use of interactive audio and video telecommunications technology to support “real time” interactive patient care and consultations between healthcare practitioners and patients at a distance.  

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
</table>
| Reimbursement policy applies to fee-for-service. Managed care plans may cover telemedicine at their own option and establish their own payment guidelines and structure.  
Telemedicine consultations are covered when medically necessary and when the following requirements are met:  
- The patient must be physically present at the originating “spoke” site; the consulting practitioner is located at the “hub” site.  
- The practitioner at the “hub” site, who is performing the consultation, must be licensed in New York State, enrolled in New York State Medicaid and credentialed and privileged at both the “hub” and “spoke” sites according to the applicable setting-specific standards.  
- The request for the telemedicine consultation, the medical necessity for the telemedicine consultation and the findings of the distant “hub site” practitioner must be documented in the patient’s medical record.  
- The telemedicine consultation must be “real time,” and provided via a fully interactive, secure two-way audio visual telecommunication system (“store-and-forward” is not covered by Medicaid).  
NY Medicaid will reimburse for medically necessary services if patient is in a certain location (see live video eligible site section) and certain requirements are met (see live video policy section).


Medicaid will cover genetic counseling services via telemedicine.


Medicaid will reimburse the “spoke” site the Federal Prospective Payment System (PPS) rate. The “spoke” site will be responsible for paying the consulting practitioner, who is located at the “hub” site. Telepsychiatric services must meet certain conditions to be eligible for Medicaid reimbursement.

Source: NY Regulations Title 14 NYCRR Section 599.17.

Providers who may deliver telemedicine services include:

- Physician specialists, including psychiatrists;
- Certified Diabetes Educators (CDEs);
- Certified Asthma Educators (CAEs or A-ECs)
- Clinical Psychologists;
- Dentists;
- Psychiatric Nurse Practitioners;
- Genetic Counselors;
- Licensed Clinical Social Workers (LCSW) and Licensed Master Social Workers (LMSW) only when employed by an Article 28 clinic. LCSWs and LMSW can only provide services to Medicaid enrollees under age 21 and pregnant women up to 60 days post-partum.


Home Telehealth

Subject to the approval of the state director of the budget, the commissioner may authorize the payment of medical assistance funds for demonstration rates or fees established for home telehealth services as defined in Section 2999-cc.

Source: NY Statute, Social Services Law SOS §367-u.

For the Home Telehealth program, a telehealth provider is:

- Licensed physician
- Licensed physician assistant
- Licensed dentist
- Licensed nurse practitioner
- Licensed registered professional nurse
- Licensed podiatrist
- Licensed optometrist
- Licensed psychologist
- Licensed social worker
- Licensed speech language pathologist or audiologist
- Licensed midwife
- Certified diabetes educator
- Certified asthma educator
- Certified genetic counselor
- Hospital
- Home care services agency
- Hospice
- Physical or occupational therapist
- Or any other provider as determined by the Commissioner.

### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Live Video</th>
<th>Eligible Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telepsychiatric services must meet certain conditions to be eligible for Medicaid reimbursement.</td>
<td></td>
</tr>
<tr>
<td><strong>Source:</strong> NY Regulations Title 14 NYCRR Section 599.17. (Accessed Sept. 2018).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligible Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York Medicaid will reimburse for live video services for medically necessary services provided to patients in:</td>
</tr>
<tr>
<td>- Hospitals (emergency room, outpatient department, Inpatient) established under Article 28 of the New York Public Health Law;</td>
</tr>
<tr>
<td>- Diagnostic and Treatment Centers (D&amp;TCs) established under Article 28 of the New York Public Health Law;</td>
</tr>
<tr>
<td>- FQHCs that have “opted into” NY Medicaid Ambulatory Patient Groups (APG);</td>
</tr>
<tr>
<td>- Non-FQHC School Based Health Centers (SBHCs);</td>
</tr>
<tr>
<td>- Practitioner offices;</td>
</tr>
<tr>
<td>- Article 28 facilities providing dental services;</td>
</tr>
</tbody>
</table>

The distant site or “hub” is where the medical specialist providing the consultation or service is located. The originating site or “spoke” is where the referring health professional and patient are located.


<table>
<thead>
<tr>
<th>Geographic Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility/Transmission Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Q3014 may be billed under certain circumstances.</td>
</tr>
</tbody>
</table>

The originating site can bill for administrative expenses only when a telepsychiatric connection is being provided and a physician or NP is not present at the originating site with the patient at the time of the encounter.

# Medicaid Telehealth Reimbursement

## Store-and-forward Policy

NY Medicaid is authorized to establish fees to reimburse the cost of telehealth store-and-forward technology, per a State Plan Amendment submitted and approved by CMS. Store-and-forward technology may be utilized in the specialty areas of dermatology, ophthalmology and other disciplines, as determined by the Commissioner. Services must reduce the need for on-site or in-office visits.


For the home telehealth program, store-and-forward services may be reimbursed.


## Remote Patient Monitoring Policy

NY Medicaid is authorized to establish fees to reimburse the cost of telehealth remote patient monitoring, per a State Plan Amendment submitted and approved by CMS.

Remote patient monitoring (RPM) can include synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data. RPM may be provided by a facility licensed under Article 28 of Public Health Law or by a physician, nurse practitioner, midwife or physician assistant who has examined the patient and with whom has an established relationship.


RPM included within definition of “telehealth” in statute requiring Medicaid not exclude from payment the delivery of home health services through telehealth.

**Source:** Social Services Law Article 367-u. (Accessed Sept. 2018).
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conditions</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Remote Patient Monitoring</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Provider Limitations</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Other Restrictions</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Email / Phone / Fax</strong></td>
</tr>
<tr>
<td>No payment for telephone.</td>
</tr>
<tr>
<td>Telepsychiatry services does not include telephone, video cell phone, or e-mail.</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
</tr>
<tr>
<td>Part of obtaining approval for telepsychiatry services is obtaining informed consent.</td>
</tr>
<tr>
<td><strong>Out of State Providers</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>NY Department of Health is encouraging Medicaid Managed Care (MMC) plans to allow for telehealth services. They are allowing MMC plans to request reimbursement of additional cost effective alternative telehealth services.</td>
</tr>
<tr>
<td>Subject to federal financial participation and the approval of the director of the budget, the commissioner shall not exclude from the payment of medical assistance funds the delivery of health care services through telehealth, as defined in subdivision four of section two thousand nine hundred ninety-nine-cc of the public health law.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth means the use of electronic information and communications technologies by a health care provider to deliver health services to an insured individual while such individual is located at a site that is different from the site where the health care provider is located.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>A health plan shall not exclude from coverage services that are provided via telehealth if they would otherwise be covered under a policy, provided that an insurer may exclude coverage of a service by a health care provider where the provider is not otherwise covered under the policy.</td>
</tr>
<tr>
<td>An insurer may subject the coverage of a service to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service not delivered via telehealth.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Parity</td>
</tr>
<tr>
<td>A health plan shall not exclude from coverage services that are provided via telehealth if they would otherwise be covered under a policy, provided that an insurer may exclude coverage of a service by a health care provider where the provider is not otherwise covered under the policy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No explicit payment parity.</td>
</tr>
</tbody>
</table>
Definitions

For the home telehealth program, term “telehealth” means the use of electronic information and communication technologies by telehealth providers to deliver health care services, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient. Telehealth shall not include delivery of health care services by means of audio-only telephone communication, facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store-and-forward technology or remote patient monitoring.


Related to Credentialing and Privileging Health Care Practitioners Providing Telemedicine

“Telemedicine means the delivery of clinical health care services by means of real time two-way electronic audio-visual communications which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care, while such patient is at the originating site and the health care provider is at a distant site.”


Telemedicine means the use of synchronous, two-way electronic audio visual communications to deliver clinical health care services, which shall include the assessment, diagnosis, and treatment of a patient, while such a patient is at the originating site and a telehealth provider is at a distant site.


Under Public Health, originating sites are limited to:

- Licensed health facilities in Articles 28 (hospitals) and 40 (hospice);
- A facility as defined in Section 1.03, subdivision six of the Mental Hygiene Law which includes and place in which services for the mentally disabled are provided and includes but is not limited to a psychiatric center, development center, institute, clinic, ward, institution or building;
- Certified and non-certified day and residential programs funded or operated by the office for people with developmental disabilities;
- Private physician’s or dentist’s offices located in New York;
- Public, private and charter elementary and secondary schools, school age childcare programs and child day care centers within the state of New York;
- Adult care facility licensed under title two of article seven of the social services law;
- The patient’s place of residence located within the state of New York or other temporary location located within or outside the state of New York.


Consent

No reference found.

Office of Alcoholism and Substance Abuse Services (OASAS)

OASAS Telepractice Standards outlines practitioner requirements for prescribing buprenorphine.

Telepsychiatry shall not be utilized in certain personalized Recovery Oriented Services program or Assertive Community Treatment programs.


Telehealth shall not include delivery of health care services by means of audio-only telephone communication, facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store-and-forward technology or remote patient monitoring.


Office for People with Developmental Disabilities (OPWDD)
Telehealth is a new mechanism that is available to deliver clinical care.

Source: OPWDD. Emergency/Proposed Regulations. 679.1(c)(4). Regulations are effective through the revision process.

Office of Alcoholism and Substance Abuse Services (OASAS)
Telepractice services may be authorized by the Office of Alcoholism and Substance Abuse Services for the delivery of certain addiction services provided by practitioners employed by or under contract by the Office as long as the practitioner and patient are in sites approved by the Office pursuant to a plan submitted by a certified program in application for a telepractice designation.


OASAS has specific telepractice standards for its providers. See regulation for details.


For the home telehealth program, store-and-forward services may be reimbursed.


The patient must be present for telepsychiatry services for Medicaid reimbursement. Telepsychiatry is also defined as “real-time”.


Demonstration rates of payment or fees shall be established for telehealth services provided by a certified home health agency, a long term home health care program or AIDS home care program, or for telehealth services by a licensed home care services agency under contract with such an agency or program, in order to ensure the availability of technology-based patient monitoring, communication and health management. Reimbursement is provided only in connection with Federal Food and Drug Administration-approved and interoperable devices that are incorporated as part of the patient’s plan of care.

The Department of Health, Office of Mental Health and Office of Alcoholism and Substance Abuse Services and Office of People with Developmental Disabilities required to coordinate on the issuance of a single guidance document that will:

- Identify any differences in regulations or policies issued by the agencies including reimbursement; and
- Be designed to assist consumers, providers and health plans in understanding and facilitating the appropriate use of telehealth in addressing barriers to care.


Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD) are prohibited from being delivered via telehealth.


Each agency that operates a clinic treatment facility shall provide the Office for People with Developmental Disabilities (OPWDD) information it requests, including but not limited to the following: services provided by CPT/HCPCS and/or CDT codes, where such services were delivered, including the location of both the provider and the individual when services are delivered via telehealth, (i.e., on-site or at a certified satellite site, or, prior to April 1, 2016, off-site) and revenues by funding source or payee. These data shall correspond to the identical time period of the cost report.

Medicaid Reimbursement

**Summary**

NC Medicaid reimburses live video telemedicine for medical and tele-psychiatry services as long as certain conditions are met. They do not provide reimbursement for store-and-forward, and make no reference to remote patient monitoring.

**Definitions**

"Telemedicine is the use of two-way real-time interactive audio and video between places of lesser and greater medical capability or expertise to provide and support health care, when distance separates participants who are in different geographical locations."


**Live Video**

North Carolina Medicaid and NC Health Choice will reimburse for live video medical services and tele-psychiatry services. All of the following conditions must be met:

- The beneficiary must be present at the time of consultation;
- The medical examination must be under the control of the consulting provider;
- The distant site of the service must be of a sufficient distance from the originating site to provide services to a beneficiary who does not have readily available access to such specialty services; and
- The consultation must take place by two-way real-time interactive audio and video telecommunications system.

Medicaid Telehealth Reimbursement

**Eligible Services / Specialties**

All services must be:

- Medically necessary;
- The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide;
- The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Providers must obtain prior approval from NC Medicaid for all services delivered via telemedicine and tele-psychiatry. Providers must submit:

- Prior approval request;
- All health records and any other records to document that the patient has met the specific criteria for teledmedicine services.

Special provisions apply for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. See manual.


**Teledentistry**

Synchronous real time dentistry is covered through D9995. Reimbursement rate TBD.


**Eligible Providers**

**Eligible medical providers:**

- Physicians;
- Nurse practitioners;
- Nurse midwives;
- Physician’s assistants.

**Eligible tele-psychiatry providers:**

- Physicians;
- Advanced practice psychiatric nurse practitioners;
- Advanced practice psychiatric clinical nurse specialists;
- Licensed psychologists Ph.D. level;
- Licensed clinical social workers (LCSW);
- Community diagnostic assessment agencies.


System changes have been completed to allow non-psychiatric Nurse Practitioners (NPs) and Physician Assistants (PAs) to receive reimbursement for the following CPT codes.

- 90791 - Psychiatric diagnostic evaluation
- 90792 - Psychiatric diagnostic evaluation with medical services

NPs and PAs enrolled in the Medicaid or North Carolina Health Choice (NCHC) programs may bill Medicaid or NCHC for these services.

### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Eligible Sites</th>
<th>Geographic Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“The distant site of the service must be of a sufficient distance from the originating site to provide services to a beneficiary who does not have readily available access to such specialty services.”</td>
</tr>
<tr>
<td></td>
<td>No reimbursement if:</td>
</tr>
<tr>
<td></td>
<td>• The recipient is located in a jail, detention center, or prison;</td>
</tr>
<tr>
<td></td>
<td>• The consulting provider is not a Medicaid-enrolled provider;</td>
</tr>
<tr>
<td></td>
<td>• The consulting provider does not follow established criteria for the service provided</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Facility/Transmission Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Originating-site provider facility fees paid to:</td>
</tr>
<tr>
<td>• Physicians;</td>
</tr>
<tr>
<td>• Nurse practitioners;</td>
</tr>
<tr>
<td>• Nurse midwives;</td>
</tr>
<tr>
<td>• Advanced practice psychiatric nurse practitioners;</td>
</tr>
<tr>
<td>• Advanced practice psychiatric clinical nurse specialists;</td>
</tr>
<tr>
<td>• Licensed psychologists (Ph.D. level);</td>
</tr>
<tr>
<td>• Licensed clinical social workers (LCSW);</td>
</tr>
<tr>
<td>• Physician’s assistants;</td>
</tr>
<tr>
<td>• Hospitals (inpatient or outpatient);</td>
</tr>
<tr>
<td>• Federally Qualified Health Centers;</td>
</tr>
<tr>
<td>• Rural Health Clinics;</td>
</tr>
<tr>
<td>• Local health departments;</td>
</tr>
<tr>
<td>• Local Management Entities.</td>
</tr>
<tr>
<td>No facility fees for distant-site providers.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Store-and-Forward Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina Medicaid will not reimburse for Store-and-forward.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Eligible Services/Specialties</th>
<th>No reference found.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Store-and-Forward</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Geographic Limits</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Transmission Fee</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Policy</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Conditions</td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Provider Limitations</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
Remote Patient Monitoring

No reimbursement for email.
No reimbursement for telephone.
No reimbursement FAX.
No reimbursement for video cell phone interaction.


Due to higher than normal number of influenza cases, NC Medicaid is offering telephonic evaluation and management services to beneficiaries. It must be rendered by a physician, nurse practitioner or physician assistant to established patients. If the phone call follows an office visit performed and reported within the past seven days for the same diagnosis, then the telephone services are considered part of the previous office visit and are not separately billed.


Consent

No reference found.

Out of State Providers

No reference found.

Criteria for eligible beneficiaries:

- Must be enrolled in the NC Medicaid program or NC Health Choice
- Providers must verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered
- The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for the NCHC Program. Children must be between the ages of 6-18 (one of many restrictions in program).
Other Limitations:

- Up to three different consulting providers may be reimbursed for a separately identifiable telemedicine or telepsychiatry service per date of service.
- Only one facility fee is allowed per date of service per beneficiary.
- There is no reimbursement to the referring provider at the originating site on the same date of service unless the referring provider is billing for a separately identifiable billable service. Health records must document that all the components of the service being billed were provided.
- These services are subject to the same restrictions as face-to-face contacts.


The Office of Rural Health and Community Care shall oversee and monitor the establishment of a statewide telepsychiatry program.


Providers must comply with the following in effect at the time the service was rendered:

- All applicable agreements, federal, state and local laws and regulations including HIPAA and medical retention requirements.
- All Medicaid’s clinical coverage policies, guidelines, policies, provider manuals, implementation updates and bulletins published by CMS, DHHS, its divisions or its fiscal agent.

# Maternal and Child Health and Women’s Health

Telemedicine is the use of audio and video between places of lesser and greater medical capability or expertise to provide and support health care when distance separates participants who are in different geographical locations.


## Consent

No reference found.

## Online Prescribing

No reference found.

## Cross-State Licensing

**Member of the Physical Therapy Compact.**

**Source:** HB 57 (2017).

**Member of the Nurses Licensure Compact.**


## Miscellaneous

**Telemedicine may be utilized for neonatal or infant echocardiograms.**


Telemedicine may be used to perform the initial examination required when an individual comes into custody of law enforcement.


Department of Health and Human Services required to study and recommend a telemedicine policy for consideration by the General Assembly & study the Psychology Interjurisdictional Compact.


The Commission is required to address follow up protocols to ensure early treatment for newborn infants diagnosed with congenital heart defects, to include telemedicine (live video).

**Source:** NC General Statute 130A-125 (Accessed Sept. 2018).
**North Dakota**

**Medicaid Program:** North Dakota Medicaid  
**Program Administrator:** North Dakota Dept. of Human Services  
**Regional Telehealth Resource Center:** Great Plains Telehealth Resource and Assistance Center  
**Covers the States of:** Iowa, Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin  
**www.gptrac.org**

<table>
<thead>
<tr>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Dakota reimburses for live video telemedicine for most services, with a few exceptions. They do not provide reimbursement for store-and-forward and no reference was found for remote patient monitoring.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
</table>
| Telemedicine is the use of interactive audio-video equipment to link practitioners and patients at different sites.  

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
</table>
| North Dakota Medicaid will reimburse for live video services as long as the patient is present during the service. Actual visual contact (face-to-face) must be maintained between practitioner and patient.  

**Telemedicine services are covered by Medicaid under the following criteria:**

- The recipient must be present during the provision of the service;  
- Be medically appropriate with necessary supporting documentation in patient’s clinical medical record;  
- The appropriate CPT codes are used by the consulting site along with a GT modifier and 95; and  
- The originating site uses HCPC code Q3014.  

*Separate long distance charges required for out-of-network sites are billable to ND Medicaid. Medicaid will pay for the actual cost charged by the telephone company.*  

**Indian Health Services**

Reimbursement for telemedicine is reimbursed at the all-inclusive rate regardless of whether the originating site is outside the “four walls” of the facility or clinic.  
### Medicaid Telehealth Reimbursement

**Live Video**

Except for the Non Covered services noted below, telemedicine can be used for services covered by Medicaid, and otherwise allowed, per CPT, to be rendered via telemedicine.

**NON COVERED SERVICES:** Therapies provided in a group setting; Store-and-forward Targeted Case Management for High Risk Pregnant Women; and Infants Targeted Case Management for Individuals in need of Long-Term Care Services.


**Eligible Providers**

Reimbursement is made for services provided by licensed professional enrolled with ND Medicaid and within the scope of practice per their licensure only.


Physicians at both the originating and consulting sites may bill for services. Supplies needed for any procedures performed are considered part of the procedure and are not separately billable.


**Eligible Sites**

No reference found.

**Geographic Limits**

No reference found.

**Facility/Transmission Fee**

Reimbursement will be made to the originating site as a facility fee only in place of service office, inpatient hospital, outpatient hospital, or skilled nursing facility/nursing facility. There is no additional reimbursement for equipment, technicians or other technology or personnel utilized in the performance of the telemedicine service.


<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>No reference found.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote Patient Monitoring</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Provider Limitations</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Other Restrictions</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

**Email / Phone / Fax**

- No reference found for email.
- No reimbursement for telephone.
- No reference found for FAX.


<table>
<thead>
<tr>
<th>Consent</th>
<th>No reference found.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of State Providers</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
### Private Payer Laws

### Definitions

**Telehealth:**
- Means the use of interactive audio, video or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws.
- Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.
- Does not include the use of audio only telephone, electronic mail, or facsimile transmissions.


### Requirements

An insurer must provide coverage for telehealth delivered health services which is the same coverage for health services delivered by in-person means.

A policy is not required to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy.


North Dakota’s Worker Compensation Act provides reimbursement for live video.

#### Eligible services:
- Office or other outpatient visits;
- New evaluation visits and established management visits;
- Individual psychotherapy visits;
- Pharmacologic management visits.

The patient must be present and participate in the appointment. The professional fee is equal to comparable in-person services. The organization may pay the originating site facility fee, not to exceed twenty dollars.


### Parity

An insurer must provide coverage for telehealth delivered services to the same extent as the same coverage for in-person services. They are not required to provide coverage for health services that are not medically necessary.


### Payment Parity

Payment of expenses may be established through negotiations conducted between the insurer and health services providers in the same manner as reimbursement of expenses for covered services that are delivered by in-person means.

“Telemedicine” means the practice of medicine using electronic communication, information technologies, 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 includes direct interactive patient encounters as well as asynchronous store-and-forward technologies and remote monitoring.


**Stroke system of care task force**

“Telemedicine services means the use of interactive audio, video, and other electronic media used for the purpose of diagnosis, consultation, or treatment of acute stroke.”

**Source:** ND Statute Sec. 23-43-05. (Accessed Sept. 2018).


“Telemedicine means the practice of medicine by a practitioner, other than a pharmacist, who is at a location remote from the patient, and is communicating with the patient, or health care professional who is treating the patient, using a telecommunications system.”


**Physical Therapy:**

“Telehealth” is the use of electronic communications to provide and deliver a host of health-related information and healthcare services, including, but not limited to physical therapy related information and services, over large and small distance. Telehealth encompasses a variety of healthcare and health promotion activities, including, but not limited to, education, advice, reminders, interventions, and monitoring of interventions.

**Source:** ND Admin. Code 61.5-01-02-01. (Accessed Sept. 2018).

**Physical Therapy:**

The physical therapist may use telehealth technology as a vehicle for providing only services that are legally or professionally authorized. The patient’s written or verbal consent will be obtained and documented prior to such consultation.

**Source:** ND Admin. Code 61.5-01-02-01. (Accessed Sept. 2018).

A valid prescription via e-prescribing means a prescription has been issued for a legitimate medical purpose, in the usual course of professional practice, by a practitioner who has first conducted an in-person medical evaluation of the patient. An in-person medical evaluation can include the referring practitioner having performed the exam, in the case of telemedicine.

## Professional Regulation/Health & Safety

### Cross-State Licensing

The ND Medical Board may engage in reciprocal licensing agreements with out-of-state licensing agencies, but is not required to do so.

**Source:** ND Century Code Sec. 43-17-21 (Accessed Sept. 2018).

Member of the Physical Therapy Compact.

**Source:** HB 1157 (2017).

Member of the Nurses Licensure Compact.


### Miscellaneous

Under the Worker’s Compensation Act, the originating sites may receive a facility fee, not to exceed $20.


The board shall provide health benefits coverage under a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2 which provides coverage of health services delivered by means of telehealth in the same manner as provided under section 26.1-36-09.15.

**Source:** ND Statute Sec. 54-52.1-04.13. (Accessed Sept. 2018).

**Professional Board Telehealth-Specific Regulations**

- North Dakota Board of Medicine

Ohio Medicaid reimburses for live video telemedicine. They do not provide reimbursement for store-and-forward or remote patient monitoring.

**Definitions**

1. "Telemedicine" is the direct delivery of services to a patient via synchronous, interactive, real-time electronic communication that comprises both audio and video elements. The following activities are not telemedicine:
   a. The delivery of service by electronic mail, telephone, or facsimile transmission;
   b. Conversations between practitioners regarding the patient without the patient present either physically or via synchronous, interactive, real-time electronic communication; and
   c. Audio-video communication related to the delivery of service in an intensive care unit.


Telehealth service means a health care service delivered to a patient through the use of interactive audio, video, or other telecommunications or electronic technology from a site other than the site where the patient is located.

   *Source: OH Revised Statute, Sec. 5164.95. (Accessed Sept. 2018).*

Ohio Medicaid covers live video telemedicine for certain eligible providers, specific services and at specified originating sites.

The department of Medicaid is required to establish standards for Medicaid payment for health care services the department determines are appropriate to be covered when provided as telehealth services.


See fact sheet for list of eligible CPT codes.


Eligible Distant Site Providers

- Physicians (MD, DO)
- Psychologists
- Federally Qualified Health Center (medical and mental health)

“Originating site” is the physical location of the patient at the time a health care service is provided through the use of telemedicine. The originating site may be one of five places:

a. The office of a medical doctor, doctor of osteopathic medicine, optometrist, or podiatrist;

b. A federally qualified health center, as defined in chapter 5160-28 of the Administrative Code, rural health center, or primary care clinic;

c. An outpatient hospital;

d. An inpatient hospital; or

e. A nursing facility.


Provider types eligible as an originating site, either using a Q3014 HCPCS code or a GQ modifier:

- Primary Care Clinic
- Outpatient Hospital
- Rural Health Clinic (Medical)
- Federally Qualified Health Clinic (Medical)
- Physician
- Professional Medical Group
- Podiatrist
- Optometrist

See fact sheet for additional billing rules.


Excluded places of service for originating or distant site providers:

- Home
- Inpatient hospital
- Nursing facility
- Inpatient psychiatric hospitals
- Other POS exclusions for E&M and psychiatric codes

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Live Video</strong></td>
</tr>
<tr>
<td>Geographic Limits</td>
</tr>
<tr>
<td>When the originating site is located within a five mile radius from the distant site, providers are not eligible for reimbursement.</td>
</tr>
<tr>
<td><strong>Facility/Transmission Fee</strong></td>
</tr>
<tr>
<td>Originating site eligible for a facility fee using HCPCS code Q3014. See transmittal letter for additional billing rules.</td>
</tr>
<tr>
<td>No originating site provider may receive both a telemedicine originating fee and payment for an evaluation and management service provided to a patient on the same day.</td>
</tr>
<tr>
<td>No institutional (facility) claim may be submitted by the distant site provider for the health care service delivered through the use of telemedicine.</td>
</tr>
<tr>
<td><strong>Policy</strong></td>
</tr>
<tr>
<td>Telemedicine is defined as being &quot;synchronous, interactive, real-time&quot;, excluding the use of store-and-forward technology.</td>
</tr>
<tr>
<td><strong>Store-and-Forward</strong></td>
</tr>
<tr>
<td>Eligible Services/Specialties</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Geographic Limits</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Electronic mail, telephone and facsimile transmission are not telemedicine.**

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Consent</th>
<th>The originating site is responsible for obtaining informed consent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of State Providers</td>
<td></td>
<td>No reference found.</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
<td>No reference found.</td>
</tr>
<tr>
<td>Definitions</td>
<td></td>
<td>No reference found.</td>
</tr>
<tr>
<td>Requirements</td>
<td></td>
<td>No reference found.</td>
</tr>
<tr>
<td>Private Payer Laws</td>
<td>Parity</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Service Parity</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Payment Parity</td>
<td>None.</td>
</tr>
</tbody>
</table>
### Definitions

**Physicians – Obtaining a Telemedicine certificate by an out of state provider.**
The practice of telemedicine means the practice of medicine in this state through the use of any communication, including oral, written, or electronic communication, by a physician located outside this state.


**Physical Therapy Practice**
“Telehealth means the use of electronic communications to provide and deliver a host of health-related information and healthcare services, including, but not limited to physical therapy related information and services, over large and small distances.”


**Speech Language Pathology**
Telehealth means the use of telecommunications and information technologies for the exchange of information from one site to another for the provision of audiology or speech-language pathology services to an individual from a provider through hardwire or internet connection.


### Consent

**Speech Language Pathology**
A provider is required to inform the patient of specific telehealth limitations.


Informed consent is required (“patient’s agreement or signed authorization”). Must be documented in patient’s record.


### Online Prescribing

A physician shall not prescribe, personally furnish or otherwise provide, or cause to be provided any controlled substance or non-controlled substance to a person on whom the physician has never conducted a physical examination, with the exceptions listed below.

**Non-Controlled Substances Exceptions**
Prescribing is allowed when a patient is remote from the physician by complying with the following:

- Establish the patient’s identity and physical location;
- Obtain the patient’s informed consent;
- Forward medical record to patient’s primary care provider (upon consent);
- Conduct an appropriate evaluation;
- Establish or confirm a diagnosis and treatment plan;
- Document information in patient’s medical record;
- Provide appropriate follow-up care;
- Make medical record of the visit available to patient; and
- Use appropriate technology sufficient to conduct all steps.

Additional restrictions apply for controlled substances. See regulation.


A patient evaluation performed within the previous twenty-four months via telemedicine by a healthcare provider acting within the scope of their professional license is acceptable for satisfying the criteria to be an “active patient.”

Ohio issues telemedicine certificates that allow the holder to engage in the practice of telemedicine in the state. Providers with telemedicine certificates cannot practice in OH without a special activity certificate.

The OH Medical Board may issue, without examination, a telemedicine certificate to a person who meets all of the following requirements:

- Holds a current, unrestricted license to practice medicine and surgery or osteopathic medicine and surgery and surgery issued by another state that requires license holders to complete at least fifty hours of continuing medical education every two years.
- The person's principal place of practice is in that state.
- The person does not hold a license issued under this chapter authorizing the practice of medicine and surgery or osteopathic medicine and surgery in this state.
- The person meets the same age, moral character, and educational requirements individuals must meet under sections 4731.09 and 4731.14 of the Revised Code and, if applicable, demonstrates proficiency in spoken English in accordance with section 4731.142 of the Revised Code.

Source: OH Revised Code Annotated, Sec. 4731.296.

The [state medical] board shall convert a telemedicine certificate to a license issued under section 4731.14 of the Revised Code on receipt of a written request from the certificate holder. Once the telemedicine certificate is converted, the holder is subject to all requirements and privileges attendant to a license issued under section 4731.14 of the Revised Code, including continuing medical education requirements.


Physical Therapy

Physical therapists and physical therapist assistants must hold a valid OH physical therapy license to treat a patient located in Ohio via telehealth.


Professional Board Telehealth-Specific Regulations

- State Board of Speech Language Pathology and Audiology (Source: OH Admin. Code 4753-2-01).
SoonerCare reimburses for live video telehealth. Store-and-Forward and Remote Patient Monitoring must be compensable by the Oklahoma Health Care Authority (OHCA) in order to be reimbursed.

For purposes of SoonerCare reimbursement, telemedicine is the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment that occur in real time and when the member is actively participating during the transmission.


Telehealth means the mode of delivering healthcare services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of patients, at a distance from health care providers.

Source: OK Admin. Code Sec. 317:30-3-27 (a).

SoonerCare (Oklahoma's Medicaid program) reimburses for live video when:

- The GT modifier is billed
- Proper documentation to include services rendered, location and services provided via telemedicine is maintained


OHCA has discretion and final authority to approve or deny telehealth services based on agency and/or SoonerCare members' needs. See Medicaid Telehealth webpage for full list of eligible CPT Codes for Medical and Behavioral Health Services. Services provided by telehealth must be billed with the appropriate modifier.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Live Video</strong></td>
</tr>
<tr>
<td><strong>Eligible Providers</strong></td>
</tr>
<tr>
<td>To participate, a provider must:</td>
</tr>
<tr>
<td>Be contracted with SoonerCare and appropriately licensed, bill for services using the appropriate modifier (GT), and maintain documentation of services, to include: service rendered, location at which service was rendered, and that service was provided via telemedicine. (Documentation of services must follow all other SoonerCare documentation guidelines as well.)</td>
</tr>
<tr>
<td><strong>Source:</strong> Source: Oklahoma Health Care Authority, Telehealth. (Accessed Sept. 2018).</td>
</tr>
<tr>
<td>For behavioral health, certain services are only reimbursed when provided by a licensed psychiatrist, certified mobile team or psychiatric facility.</td>
</tr>
<tr>
<td><strong>Eligible Sites</strong></td>
</tr>
<tr>
<td>The medical or behavioral health related service must be provided at an appropriate site for the delivery of telehealth services. An appropriate telehealth site is one that has the proper security measures in place; the appropriate administrative, physical and technical safeguards should be in place that ensures the confidentiality, integrity and security of electronic protected health information. The location of the room for the encounter at both ends should ensure comfort, privacy and confidentiality. Both visual and audio privacy are important, placement and selection of the rooms should consider this. Appropriate telehealth equipment and networks must be used considering factors such as appropriate screen size, resolution and security. Providers and/or members may provide or receive telehealth services outside of Oklahoma when medically necessary.</td>
</tr>
<tr>
<td><strong>Geographic Limits</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Facility/Transmission Fee</strong></td>
</tr>
<tr>
<td>The cost of telehealth equipment and transmission is not reimbursable by SoonerCare.</td>
</tr>
<tr>
<td><strong>Store-and-Forward</strong></td>
</tr>
<tr>
<td>Policy</td>
</tr>
<tr>
<td>Health care services delivered by telehealth such as remote patient monitoring, store-and-forward, or any other telehealth technology must be compensable by OHCA in order to be reimbursed.</td>
</tr>
<tr>
<td>If the technical component of an X-ray, ultrasound or electrocardiogram is performed during a telehealth transmission, the technical component can be billed by the provider that provided that service. The professional component of the procedure and the appropriate visit code should be billed by the provider that rendered that service.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
|                                  | Transmission Fee             | The cost of telehealth equipment and transmission is not reimbursable by SoonerCare.  
|                                  | Policy                       | Health care services delivered by telehealth such as remote patient monitoring, store-and-forward, or any other telehealth technology must be compensable by OHCA in order to be reimbursed.  
<p>|                                  | Conditions                   | No reference found. |
|                                  | Provider Limitations         | No reference found. |</p>
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Remote Patient Monitoring</th>
<th>Other Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email / Phone / Fax</td>
<td></td>
<td>No reimbursement for email.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No reimbursement for telephone.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No reimbursement for FAX.</td>
</tr>
<tr>
<td>Consent</td>
<td></td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of State Providers</td>
<td></td>
<td>A patient may receive telehealth services outside of Oklahoma when medically necessary. Out of state providers must comply with all laws and regulations of the provider’s location, including health care and telemedicine requirements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the provider is outside of Oklahoma, the provider must comply with all laws and regulations of the provider’s location, including health care and telehealth requirements.</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
<td>All telehealth activities must comply with the HIPAA Security Standards, OHCA policy, and all other applicable State and Federal laws and regulations.</td>
</tr>
</tbody>
</table>
Private Payer Laws

Definitions

“Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, including but not limited to, the treatment and prevention of strokes, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. Telemedicine is not a consultation provided by telephone or facsimile machine.”


Requirements

For services determined to be appropriately provided by means of telemedicine, health care insurer programs, workers’ compensation programs and state Medicaid managed care contracts shall not require person-to-person contact between a health care practitioner and patient.


Parity

Service Parity

If a provider determines that telemedicine is an appropriate way to deliver care, an insurer cannot require face-to-face contact.

Payment Parity

No explicit payment parity.


Professional Regulation/Health & Safety

Definitions

Telemedicine means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store-and-forward technologies, between a patient and a physician with access to and reviewing the patient’s relevant clinical information prior to the telemedicine visit. “Telemedicine” and “store-and-forward technologies” shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference or facsimile machine.


“Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, including but not limited to, the treatment and prevention of strokes, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. Telemedicine is not a consultation provided by telephone, facsimile machine nor does it include administrative applications such as billing, contracted services, security systems, etc.”

This definition excludes phone or Internet contact or prescribing and other forms of communication, such as web-based video, that might occur between parties that does not meet the equipment requirements as specified in OAC 435:10-7-13 and therefore requires an actual face-to-face encounter. Telemedicine physicians who meet the requirements of OAC 435:10-7-13 do not require a face-to-face encounter.


“Telemedicine” means the practice of health care delivery, diagnosis, consultation, evaluation, treatment, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. Telemedicine uses audio and video multimedia telecommunication equipment which permits two-way real time communication between a health care practitioner and a patient who are not in the same physical location. Telemedicine shall not include consultation provided by telephone or facsimile machine.


Telepractice means the use of audio, video or data communication to provide speech-language pathology and audiology services to clients who are not present at the same site as the licensee when the service is provided.


Written consent required.


A physician-patient relationship can be established, provided that a physician:

- Holds a license to practice medicine in this state;
- Confirms the patient's identity; and
- Provides the patient with the treating physician's identity and professional credentials.

Telemedicine encounters involving store-and-forward technology shall not be used to establish a valid physician-patient relationship for purpose of prescribing opiates, synthetic opiates, semisynthetic opiates, benzodiazepine or carisprodol, but may be used to prescribe opioid antagonists or partial agonists.

The relationship shall not be based solely on the receipt of patient health information by a physician.


Prescribing or administering a drug or treatment without sufficient examination and the establishment of a valid physician-patient relationship is prohibited.


Telemedicine physicians who meet certain criteria are not subject to the face-to-face requirement to establish a physician-patient relationship.


A physician-patient relationship includes an in-person patient exam.

<table>
<thead>
<tr>
<th>Cross-State Licensing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician treating patients in OK through telemedicine must be fully licensed in OK.</td>
<td><strong>Source:</strong> OK Admin Code Title 435:10-7-13. (Accessed Sept. 2018).</td>
</tr>
<tr>
<td>The State Board of Osteopathic Examiners has the authority to issue a telemedicine license.</td>
<td><strong>Source:</strong> OK Statute, Title 59, Sec. 633. (Accessed Sept. 2018).</td>
</tr>
<tr>
<td>Member of Nurse Licensure Compact.</td>
<td><strong>Source:</strong> Nurse Licensure Compact. Current NLC States and Status.</td>
</tr>
<tr>
<td>Member of Physical Therapy Compact.</td>
<td><strong>Source:</strong> HB 3336 (2018), PT Compact.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>OK provides, at no cost, one telecommunications line or wireless connection for telemedicine services to the following:</td>
<td></td>
</tr>
<tr>
<td>• Not-for-profit hospitals;</td>
<td></td>
</tr>
<tr>
<td>• County health departments;</td>
<td></td>
</tr>
<tr>
<td>• City-county health departments;</td>
<td></td>
</tr>
<tr>
<td>• Not-for-profit mental health and substance abuse facility;</td>
<td></td>
</tr>
<tr>
<td>• Oklahoma Department of Corrections;</td>
<td></td>
</tr>
<tr>
<td>• Federally Qualified Health Centers.</td>
<td><strong>Source:</strong> OK Statutes, Title 17 Sec. 139.109. (Accessed Sept. 2018).</td>
</tr>
<tr>
<td>The OK Dept. of Health has begun to develop a statewide telemedicine network.</td>
<td><strong>Source:</strong> Oklahoma Statutes, Title 63 Sec. 1-2702. (Accessed Sept. 2018).</td>
</tr>
</tbody>
</table>

**Professional Board Telehealth-Specific Regulations**

- State Board of Medical Licensure and Supervision. **Source:** (OAC 435:10-7-13) (Accessed Sept. 2018).
**Medicaid Program:** Oregon Medicaid  
**Program Administrator:** Oregon Health Authority  
**Regional Telehealth Resource Center:** Northwest Regional Telehealth Resource Center  
**Covers the States of:** Idaho, Montana, Oregon, Utah, Washington, and Wyoming  
[https://www.nrtrc.org](https://www.nrtrc.org)

| Medicaid Telehealth Reimbursement |  
|---|---|
| **Summary** | Oregon Medicaid provides reimbursement for live video and audio under some circumstances. Store-and-forward and remote patient monitoring are not reimbursed.  

| Telemmedicine is the use of medical information, exchanged from one site to another, via telephonic or electronic communications, to improve a patient’s health status.”  

<table>
<thead>
<tr>
<th><strong>Live Video</strong></th>
<th><strong>Policy</strong></th>
</tr>
</thead>
</table>
| Oregon Medicaid will reimburse for live video when billed services comply with their billing requirements.  
The referring provider is not required to be present with the client for the consult.  
The referring provider may bill an evaluation and management code for the patient visit only if a separately identifiable visit is performed. The visit must meet all of the criteria of the code billed.  
The authority must provide coverage for behavioral health telemedicine services to the same extent that the service would be covered if they were provided in-person.  
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Live Video</th>
<th>Eligible Services / Specialties</th>
<th>Eligible Providers</th>
<th>Eligible Sites</th>
<th>Geographic Limits</th>
<th>Facility/Transmission Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Behavioral health services identified as allowable for telephonic delivery are listed in the fee schedule.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>Oregon Medicaid will provide transmission fees for originating sites.</td>
</tr>
</tbody>
</table>
Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Policy</th>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Store-and-Forward</td>
<td>Other forms of telecommunications, such as telephone calls, images transmitted via facsimile machines and electronic mail are services not covered:</td>
</tr>
<tr>
<td></td>
<td>• When those forms are not being used in lieu of videoconferencing, due to limited videoconferencing equipment access; or</td>
</tr>
<tr>
<td></td>
<td>• When those forms and specific services are not specifically allowed per the Health Service Prioritized List and Practice Guideline.</td>
</tr>
<tr>
<td></td>
<td><strong>Source:</strong> Div. of Medical Assistance Programs, Medical-Surgical Svcs. Rulebook, Div. 130, 410-130-0610. (Accessed Sep. 2018).</td>
</tr>
</tbody>
</table>

**Behavioral Health Services Manual:**
Unless specifically authorized by OAR 410-120-1200 other types of telecommunication are not covered such as images transmitted via facsimile machines and electronic mail when:

| | Those methods are not being used in lieu of videoconferencing, due to limited video conferencing equipment access; or |
| | Those methods and specific services are not specifically allowed pursuant to the Oregon Health Evidence Review Commission’s Prioritized List of Health Services and Evidence Based Guidelines. |
| | **Source:** Div. of Medical Assistance Programs, Behavior Health Services Rulebook, Div. 172, 410-172-0850. (Accessed Sep. 2018). |

<p>| Eligible Services/Specialties | No reference found. |
| Gambling Services | No reference found. |
| Geographic Limits | No reference found. |
| Transmission Fee | No reference found. |</p>
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Email / Phone / Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote Patient Monitoring</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Conditions</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Provider Limitations</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Other Restrictions</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

E-mail and telephone is reimbursed when used for patient consulting and “when billed services comply with the practice guidelines set forth by the Health Service Commission (HSC), applicable HSC approved CPT code requirements and are delivered consistent with the HSC practice guideline.” Telephone and e-mail services used in behavioral health must instead comply with the practice guidelines set forth by the Health Evidence Review Commission (HERC) and applicable HERC approved CPT code requirements and be delivered consistent with the HERC Evidence-Based Guidelines.

E-mail, telephone and fax may be used when videoconferencing is not available.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Consent</th>
<th>No reference found.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Out of State Providers</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
|                                  | Miscellaneous | The referring and evaluating practitioner must be licensed to practice medicine within the state of Oregon or within the contiguous area of Oregon and must be enrolled as a Division of Medical Assistance Programs (Division) provider.


| Private Payer Laws | Definitions | Treatment of Diabetes
|--------------------|-------------| “Telemedical means delivered through a two-way electronic communication, including but not limited to video, audio, Voice over Internet Protocol or transmission of telemetry that allows a health professional to interact with a patient, a parent or guardian of a patient or another health professional on a patient’s behalf, who is at an originating site.”

Source: OR Revised Statutes Sec. 743A.185(c).

| Requirements | Health plans must provide coverage of a health service that is provided using synchronous two-way interactive video if the service would be covered when provided in-person, it is a medically necessary service, the service is determined to be safely and effectively provided using live video according to generally accepted health care practices and standards and the technology and application to provide the service meets all standards required by state and federal laws governing privacy and security of protected health information. Plans are not required to reimburse a health professional for a service that is not a covered benefit under the plan or who has not contracted with the plan.

Source: OR Revised Statutes Sec. 743A.059(5).
Oregon requires a health benefit plan to provide coverage of a health service that is provided using synchronous two-way interactive video conferencing if:

- The plan provides coverage of the health service when provided in-person by a health professional;
- The health service is medically necessary;
- The health service is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and
- The application and technology used to provide the health service meet all standards required by state and federal laws governing the privacy and security of protected health information.

Plans may not distinguish between originating sites that are rural and urban in providing coverage.

Coverage is subject to the terms and conditions of the health benefit plan and the reimbursement specified in the contract between the plan and the health professional.

Source: OR Revised Statutes Sec. 743A.058.

A health benefit plan must provide coverage in connection with the treatment of diabetes if:

- The plan provides coverage of the health service when provided in-person;
- The service is medically necessary;
- The telemedical health service relates to a specific patient; and
- One of the participants in the telemedical health service is a representative of an academic health center.

A health benefit plan may subject coverage of a telemedical health service to all terms and conditions of the plan, including but not limited to deductible, copayment or coinsurance requirements that are applicable to coverage of a comparable health service when provided in-person.

Source: OR Revised Statutes Sec. 743A.185.

No explicit payment parity.
Health Care Provider Incentive Program
“Telehealth” means the provision of health services from a distance using electronic communications.


Community Treatment and Support Services
Telehealth means a technological solution that provides two-way, video-like communication on a secure line.


Dental Care Services
Telehealth means a variety of methods, through the use of electronic and telecommunications technologies, for the distance delivery of health care services, including dental care services and clinical information designed to improve a patient’s health status and to enhance delivery of the health care services and clinical information.

Source: OR Revised Statutes 679.543(1).

Health Planning
“Telemedicine means the provision of health services to patients by physicians and health care practitioners from a distance using electronic communications.”

Source: OR Revised Statutes 442.015(26).

Board of Chiropractic Examiners
“Telehealth” means a variety of methods, through the use of electronic and telecommunications technologies, for the distance delivery of health care services, including chiropractic services, excluding in-person services, and clinical information designed to improve the health status of a patient, and to enhance delivery of the health care services and clinical information.


Physical Therapy
“Telehealth service means a physical therapy intervention, including assessment or consultation that can be safely and effectively provided using synchronous two-way interactive video conferencing, or asynchronous video communication, in accordance with generally accepted healthcare practices and standards. For purposes of these rules, ‘telehealth service’ also means, or may be referred to, as ‘telepractice, teletherapy, or telerehab’.”

Source: OR Administrative Rule, Sec. 848-040-0100(13).

Consent
Community Treatment and Support Services
Individuals have a right to consent to services prior to the start of services, except in a medical emergency or as otherwise permitted by law.

Source: OR Administrative Rule, Sec. 309-032-0341(e).

Physical Therapy
Patient consent is required prior to initiating telehealth services.

Source: OR Administrative Rules, Sec. 848-040-0180(3).

Online Prescribing
No reference found.
Member of the Physical Therapy Compact.


Out-of-state physicians may receive a license to practice across state lines in Oregon, as long as they are fully licensed in another state and meet certain requirements.

Source: OR Revised Statutes Annotated Sec. 677.139.

A physician granted a license to practice medicine across state lines has the same duties and responsibilities and is subject to the same penalties and sanctions as any other provider licensed in Oregon, including but not limited to:

- A physician shall establish a physician-patient relationship;
- Make a judgment based on some type of objective criteria upon which to diagnose, treat, correct or prescribe;
- Act in the best interest of the patient; and
- Writing prescriptions based only on an Internet sale or consults is prohibited.

Source: OR Admin. Rules, 847-025-0000.

Oregon requires out-of-state physicians to acquire active tele-monitoring status through the Oregon Medical Board before they can perform intraoperative tele-monitoring on patients during surgery.

The Administrative Code defines "tele-monitoring" as the "intraoperative monitoring of data collected during surgery and electronically transmitted to a physician who practices in a location outside of Oregon via a telemedicine link for the purpose of allowing the monitoring physician to notify the operating team of changes that may have a serious effect on the outcome or survival of the patient. The monitoring physician is in communication with the operation team through a technician in the operating room."

Requirements:

- The facility where the surgery is performed must be a licensed hospital or ambulatory surgical center;
- The facility must grant medical staff membership and/or clinical privileges to the monitoring physician;
- The facility must request the Board grant Telemonitoring active status to the monitoring physician.

Source: OR Admin. Rules. 847-008-0023.

Professional Board Telehealth-Specific Regulations

- Dental Care Services (Source: OR Revised Statutes 679.543(1)).
- Occupational Therapy (Source: OR Admin. Code 339-010-0006).
- Board of Chiropractic Examiners (Source: OAR 811-0105-0066 - Expires 9/26/18).
## Pennsylvania

**Medicaid Program:** Pennsylvania Medical Assistance Program (MA)

**Program Administrator:** PA Department of Public Welfare

**Regional Telehealth Resource Center:** Mid-Atlantic Telehealth Resource Center

**Covers the States of:** Delaware, Kentucky, Maryland, New Jersey, North Carolina, Pennsylvania, Virginia, West Virginia, and Washington DC.

[https://www.matrc.org](https://www.matrc.org)

### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Live Video</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary</strong></td>
<td>The Pennsylvania Medical Assistance Program provides reimbursement for live-video under some circumstances. There is no reimbursement available for store-and-forward or remote patient monitoring.</td>
</tr>
</tbody>
</table>

**Definitions**

Telemedicine is the use of real-time interactive telecommunications technology that includes, at a minimum, audio and video equipment as a mode of delivering consultation services.


**For FQHCs & RHCs**

Telepsychiatry Services — Only applicable to Behavioral Health Managed Care delivery system claims and not fee-for-service delivery. Service is in real-time, interactive audio-video transmission and do not include phone, email or facsimile transmission. Consultation between two healthcare practitioners do not count as a qualifying service. Service providers are limited to psychologists and psychiatrists. Service providers are required to have a service description approved by the Office of Mental Health and Substance Abuse Services and deliverable through the managed care option.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Pennsylvania Medicaid will provide reimbursement for live video to all Medicaid enrolled physician specialists.</th>
</tr>
</thead>
</table>
| **Eligible Providers (fee for service):** | • Physicians  
• Certified registered nurse practitioners  
• Certified nurse midwives |
<p>| <strong>Providers under a managed care system should contact the appropriate managed care organization.</strong> | Source: PA Department of Public Welfare, Medical Assistance Bulletin 09-12-31, 31-12-31, 33-12-30, May 23, 2012 (Accessed Sep. 2018). |
| <strong>Providers must have documented endorsement to deliver mental services through telepsych from the county mental health program and the HealthChoices Behavioral Health Managed Care Organization, and this endorsement must be submitted to the PA Office of Mental Health and Substance Abuse Services regional office for final approval.</strong> | Source: PA Department of Public Health, Medical Assistance Bulletin OMHSAS-14-01, Mar. 18, 2014 (Accessed Sep. 2018). |
| <strong>Eligible Sites</strong> | A patient is allowed to access a telemedicine consultation at any enrolled office of the referring provider or any other participating physicians, certified registered nurse practitioner, or certified nurse midwife. |
| <strong>A site where an individual is receiving telepsych services must have an Office of Mental Health and Substance Abuse Services approved program description and be enrolled in the Medical Assistance Program.</strong> | Source: PA Department of Public Welfare, Medical Assistance Bulletin 09-12-31, 31-12-31, 33-12-30, May 23, 2012 (Accessed Sep. 2018). |</p>
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Live Video</strong></td>
</tr>
<tr>
<td>Services should be rendered face-to-face whenever practical and appropriate. Providers may consider if the recipient must travel more than 60 minutes in a rural area or 30 minutes in an urban area.</td>
</tr>
<tr>
<td><strong>Facility/transmission fee</strong></td>
</tr>
<tr>
<td>Originating site may bill for facility fee.</td>
</tr>
<tr>
<td><strong>Policy</strong></td>
</tr>
<tr>
<td>Pennsylvania Medicaid will not reimburse for store-and-forward because a telemedicine consultation must consist of a two-way, real-time interactive communication between the patient and the physician at the distant site.</td>
</tr>
<tr>
<td><strong>Store-and-forward</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Geographic limits</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Transmission fee</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Remote Patient Monitoring</td>
</tr>
<tr>
<td>Policy</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>Conditions</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>Provider Limitations</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>Other Restrictions</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>Email / Phone / Fax</td>
</tr>
<tr>
<td>No reimbursement for email.</td>
</tr>
<tr>
<td>No reimbursement for telephone.</td>
</tr>
<tr>
<td>No reimbursement for FAX.</td>
</tr>
<tr>
<td>Consent</td>
</tr>
<tr>
<td>Informed consent is required from individuals participating in any services utilizing telepsych.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous</th>
<th>Definitions</th>
<th>No reference found.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Private Payer Laws</th>
<th>Requirements</th>
<th>No reference found.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parity</th>
<th>Service Parity</th>
<th>No reference found.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Payment Parity</th>
<th>No reference found.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Regulation/Health &amp; Safety</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Definitions</td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td>Consent</td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td>Online Prescribing</td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td>Cross-State Licensing</td>
<td></td>
</tr>
<tr>
<td>Member of the Interstate Medical Licensure Compact.</td>
<td></td>
</tr>
<tr>
<td><strong>Source:</strong> The IMLC. Interstate Medical Licensure Compact. (Accessed Sep 2018).</td>
<td></td>
</tr>
<tr>
<td>Pennsylvania issues extraterritorial licenses that allow practice in Pennsylvania to physicians residing or practicing with unrestricted licenses in an adjoining state, near the Pennsylvania boundary, and whose practice extends into Pennsylvania.</td>
<td></td>
</tr>
<tr>
<td>Pennsylvania bases the granting of this license on the availability of medical care in the area involved, and whether the adjoining state extends similar privileges to Pennsylvania physicians.</td>
<td></td>
</tr>
<tr>
<td><strong>Source:</strong> PA Statutes Annotated, Title 63 Sec. 422.34(e) and (c)(2)</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
</tr>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
</tbody>
</table>
Rhode Island

Medicaid Program: Rhode Island Medical Assistance Program

Program Administrator: Rhode Island Dept. of Human Services

Regional Telehealth Resource Center: Northeast Telehealth Resource Center


http://netrc.org

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Rhode Island Medical Assistance Program reimburses for some live-video services and provides no reimbursement for store-and-forward or remote patient monitoring.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rhode Island Medicaid’s fee schedule lists several telehealth service CPT codes related to follow-up and inpatient telehealth consultations under procedure/professional services.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Eligible Services / Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reimbursement is available for initial inpatient telehealth consultation and follow-up inpatient telehealth consultation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Eligible Providers</th>
<th>Eligible Sites</th>
<th>Geographic Limits</th>
<th>Facility/Transmission Fee</th>
<th>Policy</th>
<th>Eligible Services/Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Video</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
<tr>
<td>Store-and-Forward</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent</td>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of State Providers</td>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>No reference found.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Private Payer Laws**

**Definitions**

“Telemedicine” means the delivery of clinical health care services by means of real time two-way electronic audiovisual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, treatment, and care management of a patient’s health care while such patient is at an originating site and the health care provider is at a distant site, consistent with applicable federal laws and regulations. Telemedicine does not include an audio-only telephone conversation, email message or facsimile transmission between the provider and patient, or an automated computer program used to diagnose and/or treat ocular or refractive conditions.

*Source: RI General Law, Sec. 27-81-3(12).*

**Requirements**

Each health insurer that issues individual or group accident-and-sickness insurance policies for health-care services and/or provides a health-care plan for health-care services shall provide coverage for the cost of such covered health-care services provided through telemedicine services.

*Source: RI General Law, Sec. 27-81-4(a).*
### Private Payer Laws

#### Parity - Service Parity

A health insurer shall not exclude a health care service for coverage solely because the health care service is provided through telemedicine and is not provided through in-person consultation or contact, subject to the terms and conditions of a telemedicine agreement between the insurer and provider.

*Source: RI General Law, Sec. 27-81-4(b)*.

#### Payment Parity

No explicit payment parity.

### Professional Regulation/Health & Safety

#### Definitions

Telemedicine is defined very generally as the delivery of healthcare where there is no in-person exchange. Telemedicine, more specifically, is a mode of delivering healthcare services and public health utilizing information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health care providers.


#### Consent

Informed consent should be employed for the use of patient-physician email and other text-based communications.

The agreement should include:

- Types of transmissions that will be permitted
- Circumstances when alternate forms of communication or office visits should be utilized
- Security measures
- Hold harmless clause for information lost due to technical failures
- Requirement for express patient consent to forward patient-identifiable information to a third party
- A statement noting that the patient’s failure to comply with the agreement may result in termination of the e-mail relationship


#### Online Prescribing

An established in-person physician-patient relationship is required prior to prescribing controlled substances. There is an exception where a covering physician may prescribe a controlled substance if an established coverage agreement is in place and the quantity reflects the prescription is only for a short duration.

**Cross-State Licensing**

RI allows physicians who have a license in good standing in another state to consult with RI licensed physicians or provide teaching assistance for no more than seven days unless extended with written permission from the director.

Physicians not present in RI may not provide consultation to a patient without an established physician-patient relationship, unless that patient is in the physical presence of a physician licensed in RI.

*Source: RI General Law, Sec. 5-37-16.2(a)(3).*

**Miscellaneous**

Telemedicine does not include an audio-only telephone conversation, email message or facsimile transmission between the provider and patient.

*Source: RI General Law, Sec. 27-81-3(12).*

See Department of Health Policy for Department of Health Telemedicine Guidelines for other requirements on RI providers.

**South Carolina**

**Medicaid Program:** South Carolina Medicaid  
**Program Administrator:** South Carolina Health and Human Services Dept.  
**Regional Telehealth Resource Center:** Southeastern Telehealth Resource Center  
**Covers the States of:** Alabama, Florida, Georgia, and South Carolina  
[http://www.setrc.us](http://www.setrc.us)

---

<table>
<thead>
<tr>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Carolina Medicaid reimburses for live video under certain circumstances. Store-and-forward is not reimbursed as it does not meet established conditions for the use of telemedicine. The South Carolina Medicaid reimburses for home health monitoring through the Home Aging Program for some conditions when a patient is eligible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
</table>
| “Telemedicine is the use of medical information about a patient that is exchanged from one site to another via electronic communications to provide medical care to a patient in circumstances in which face-to-face contact is not necessary.  

In this instance, a physician or other qualified medical professional has determined that medical care can be provided via electronic communication with no loss in the quality or efficacy of the care.  

Electronic communication means the use of interactive telecommunication equipment that typically includes audio and video equipment permitting two-way, real-time interactive communication between the patient and the physician or practitioner at the referring site. Telemedicine includes consultation, diagnostic, and treatment services.” |


<table>
<thead>
<tr>
<th>Live Video</th>
</tr>
</thead>
</table>
| South Carolina Medicaid will reimburse for live video and covers telemedicine when the service is medically necessary and under the following circumstances:  

- The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary’s need;  
- The medical care can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide. |

If there are technological difficulties in performing a medical assessment or problems in a beneficiaries’ understanding of telemedicine, face-to-face care must be provided instead.


Telemedicine equipment and transmission must permit encrypted transmission and the speed and image resolution must be technically sufficient to support the service billed. Staff involved in a telemedicine visit must be trained in the use of the telemedicine equipment and component in its operation.


Reimbursement to the health professional delivering the medical service is the same as the current fee schedule amount for the service provided. See appropriate professional manuals for CPT codes. Codes must be billed along with the telemedicine GT modifier.


Telepsychiatry
To qualify for reimbursement, interactive audio and video equipment that permits two-way real-time or near real-time communication with the client, consultant, interpreter, and referring clinician.

Additional requirements include:

- Reimbursement requires the “real-time” presence of a client.
- Reimbursement is available for psychiatric diagnosis assessment with Medicaid and medical evaluation and management codes.
- GT modifier must be used when billing for telepsychiatric services.
- All equipment must operate at a minimum communication transfer rate of 384 kbps.


Eligible services include consultation, diagnostic, and treatment services:

- Office or other outpatient visits;
- Inpatient consultation;
- Individual psychotherapy;
- Pharmacologic management;
- Psychiatric diagnostic interview examination and testing;
- Neurobehavioral status examination;
- Electrocardiogram interpretation and report only;
- Echocardiography.

Services provided by allied health professionals are not covered.

Telemedicine services are not an expansion of covered services, but an option for the delivery of certain covered services.

## Medicaid Telehealth Reimbursement

### Eligible Services / Specialties

**Telepsychiatry**
Psychiatric Diagnostic assessment with medical services to assess or monitor the client's psychiatric and/or physiological status may be provided via telehealth. These community mental health services are ineligible:

- Injectables;
- Nursing services;
- Crisis intervention;
- Individual, family, group and multiple family psychotherapy;
- Psychological testing which require “hands-on” encounters;
- Mental health assessment by non-physician; and
- Service Plan Development.


**Autism Spectrum Disorder**
Telehealth is not covered.


### Eligible Providers

Distant site eligible, reimbursed providers:

- Physicians;
- Nurse practitioners.
- Physician Assistants.

Distant (consultant) sites must be located in the SC Medical Service Area, which is the state of SC and areas in NC and GA within 25 miles of the SC border.


### Eligible Sites

Eligible originating (referring) sites:

- Practitioner offices;
- Hospitals (inpatient and outpatient);
- Rural Health Clinics;
- Federally Qualified Health Centers;
- Community Mental Health Centers;
- Public Schools;
- Act 301 Behavioral Health Centers.

Referring sites (also known as originating sites) must be located in the South Carolina Medical Service Area, which is the state of SC and areas in NC and GA within 25 miles of the SC border.


A patient site presenter may be required to facilitate the delivery of the service.

**Telepsychiatry**
Psychiatric diagnostic assessments (via telepsychiatry) may be provided in:

- A client’s home;
- An inpatient or outpatient general hospital;
- A Community Mental Health Center;
- School;
- Nursing Facility; or
- Other approved facility


**Geographic Limits**
Distant (consultant) sites must be located in the SC Medical Service Area, which is the state of SC and areas in NC and GA within 25 miles of the SC border.


**Facility/Transmission Fee**
The referring site is only eligible to receive a facility fee for telemedicine services. Claims are submitted with HCPCS code Q3014. If a provider performs separately identifiable service for a beneficiary on the same day as telemedicine, documentation of both services must be clearly and separately identified in the medical record and both services are eligible for reimbursement.

RHCs and FQHCs are eligible to receive a facility fee for telemedicine services when operating as the referring site. They may not bill encounter T1015 code if these are the only services being rendered.

Hospital providers are eligible to receive a facility fee for telemedicine when operating as the referring site. Claims must be submitted with revenue code 780.


**Store-and-Forward**
South Carolina Medicaid will not reimburse for store-and-forward due to the requirements that the beneficiary must be present and participating in the visit and interactive audio and video telecommunication must be used.


**Policy**
No reference found.
### Medicaid Home Again Program for Community Long Term Care

Medical telemonitoring will be of body weight, blood pressure, oxygen saturation, blood glucose levels, and basic heart rate information. Providers must meet certain conditions to participate.

**Services to be provided:**

- Unit of service is one day of direct telemonitoring provided to/for a participant in the participant's place of residence.
- The equipment must record at a minimum body weight, blood pressure, oxygen saturation, blood glucose, and basic heart rate information. Data must be transmitted electronically and any transmission costs shall be incurred by the provider of the telemonitoring service.
- Daily reimbursement rate is inclusive of monitoring of data, charting data from the monthly monitoring, visits or calls made to the home to follow up with the participants and/or caregiver, phone calls made to primary care physician(s) that are necessary while the participant is receiving the telemonitoring service, all installation of the equipment in the home and training on the equipment's use and care in the home, including equipment removal.
- Provider shall provide telemonitoring service seven days per week for all authorized time periods.


### Conditions

Community Choices waiver participants must have a primary diagnosis of:

- Insulin Dependent Diabetes Mellitus;
- Hypertension;
- Chronic Obstructive Pulmonary Disease; and/or
- Congestive Heart Failure

Providers must:

- Have equipment that records at a minimum the participant’s body weight, blood pressure, oxygen saturation, blood glucose levels, and basic heart rate information. All agencies must also have nursing personnel and health care professionals able to carry out specific duties.
- Agree to participate in all components of the Care Call payment system and have the capability to receive and respond to authorizations for service in an electronic format.
- Have at least one year of experience or otherwise demonstrate competency in the provision of this service.


Remote Patient Monitoring

Community Choices waiver participants must meet the following criteria to participate:

- Have a primary diagnosis of Insulin Dependent Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease and/or Congestive Heart Failure; and
- History of at least two hospitalizations and/or emergency room visits in the past 12 months; and
- Have a primary care physician that approves the use of telemonitoring service and is solely responsible for receiving and acting upon the information received via the service; and
- Be capable of using the telemonitoring equipment and transmitting the necessary data or have an individual available to do so.

Other requirements on staffing, background checks, installation, equipment, conduct of service and administration are required.


Other Restrictions

No reimbursement for email.
No reimbursement for telephone.
No reimbursement for FAX.
No reimbursement for video cell phone interactions.


Licensed Independent Practitioner’s Rehabilitative Services.

Service Plan Development, crisis management and consultations between psychologists/LPES to families, schools or other health care providers can be provided telephonically.


Telephone contact related to office procedures or appointment times are not covered.


Consent

A patient’s written consent is required prior to the dissemination of any of their images or information to other entities.


A patient may withdraw from the use of telemedicine at any time.

If a beneficiary is a minor child, a parent and/or guardian must present the child for telemedicine services unless otherwise exempted by State or Federal law. The parent and/or guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.

Documentation to substantiate the services provided must be maintained at the medical records at referring and consulting locations. The documentation must include an indication that services were rendered via telemedicine and all other Medicaid documentation guidelines apply. The beneficiary has access to all transmitted medical information, with the exception of live interactive video, as there is often no stored data in such encounters.

### Definitions

**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 practitioner.


South Carolina law addresses telemedicine under veterinary services, stating, “telemedicine is an audio, video, or data communication of medical information.”


### Consent

No reference found.

### Online Prescribing

A licensee shall not establish a physician-patient relationship by telemedicine for the purpose of prescribing medication when an in-person physical examination is necessary for diagnosis. Schedule II and Schedule III prescriptions are not permitted except for those Schedule II and Schedule III medications specifically authorized by the board, which may include, but not be limited to, Schedule II-nonnarcotic and Schedule III-nonnarcotic medications.

To establish a physician-patient relationship via telemedicine, the provider must:

- Comply with state and federal laws on patient confidentiality
- Adhere to current standards of practice
- Provide an appropriate examination
- Verify the identity and location of the patient and be prepared to inform the patient of the licensee’s name, location and professional credentials
- Establish a diagnosis through the use of accepted medical practices
- Ensure availability of follow-up care
- Prescribe within a practice setting fully in compliance with the law
- Maintain a complete record of the patient’s care
- Maintain the patient’s records’ confidentiality
- Be licensed to practice in South Carolina
- Be trained in the use of telemedicine

Schedule II and III prescriptions are not permitted except as specifically authorized by the board.


### Cross-State Licensing

The physician must be licensed in South Carolina; however, they do not need to reside in South Carolina.

*Source: SC Code Annotated Sec. 40-47-37(9).*

Member of the Physical Therapy Compact.


Member of the Nurse Licensure Compact.

Professional Board Telehealth Specific Regulations

• SC Board of Occupational Therapy (Source: SC OT Board eNews. Apr. 2010)
South Dakota Medicaid provides reimbursement for live video at the same rate as in-person services, under some circumstances. Reimbursement is not provided for store-and-forward or remote patient monitoring services.

“Telemedicine is the use of an interactive telecommunications system to provide two-way, real-time, interactive communication between a provider and a Medicaid recipient across a distance.”


**Office of Adult Services and Aging**
“Telehealth services” is a home-based health monitoring system used to collect and transmit an individual’s clinical data for monitoring and interpretation.


South Dakota Medicaid will reimburse for limited services at the same rate as in-person services. See manual for complete list of CPT codes.

All telemedicine services must comply with South Dakota Medicaid’s Out-Of-State Prior Authorization Requirements.


See manuals for specific CPT codes.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Live Video</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Eligible Providers</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Eligible Sites</strong></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
| **Geographic Limits**           | An originating site may not be located in the same community as the distant site, unless the originating site is a nursing facility.  
| **Facility/Transmission Fee**   | Originating sites are eligible for a facility fee.  
| **Policy**                      | South Dakota Medicaid defines telemedicine as occurring in “real-time”, excluding store-and-forward applications.  
### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Service</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Services/Specialties</td>
<td>- No reference found.</td>
</tr>
<tr>
<td>Geographic Limits</td>
<td>- No reference found.</td>
</tr>
<tr>
<td>Transmission Fee</td>
<td>- No reference found.</td>
</tr>
</tbody>
</table>
| Policy                 | The Office of Adult Services and Aging defines “telehealth services” as a home-based health monitoring system used to collect and transmit an individual’s clinical data for monitoring and interpretation. However, no further information is provided.  
  
<p>| Conditions             | - No reference found.                                                   |
| Provider Limitations   | - No reference found.                                                   |</p>
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Remote Patient Monitoring</th>
<th>Other Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- No reimbursement for phone.
- No reimbursement for email.
- No reimbursement for facsimile.


<table>
<thead>
<tr>
<th>Email / Phone / Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reimbursement for phone.</td>
</tr>
<tr>
<td>No reimbursement for email.</td>
</tr>
<tr>
<td>No reimbursement for facsimile.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out of State Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Private Payer Laws</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>Professional Regulation/Health &amp; Safety</td>
</tr>
<tr>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>Definitions</td>
</tr>
<tr>
<td>&quot;Telehealth services&quot; is a home-based health monitoring system used to collect and transmit an individual's clinical data for monitoring and interpretation.</td>
</tr>
</tbody>
</table>

**Mental Health Procedures in Criminal Justice**

"Telehealth" is a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from health care providers.


<table>
<thead>
<tr>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>
Professional Regulation/Health & Safety

Online Prescribing

No reference found.

Cross-State Licensing

An applicant who holds a valid medical license issued by another state can be licensed through reciprocity in South Dakota if:

- The applicant completed a residency program in the US or Canada;
- Has passed one of the listed licensure examinations. (Please see rule for list);
- Is in good standing with their state’s professional board; and
- Has completed a state and federal criminal background investigation.


Member of Interstate Medical Licensure Compact.


Member of Nurse Licensure Compact.


Miscellaneous

Office of Adult Service and Aging

In-home services, which is defined as including “telehealth services”, may be provided to an individual who demonstrates a need for long-term supports and services through an assessment and the following criteria:

- The individual is residing at home;
- The individual is age 60 or older or is age 18 or older with a disability; and
- The individual is not eligible for other programs which provide the same type of service.

TennCare reimburses for live video only for crisis-related services. TennCare services are offered through managed care entities. Each MCO has its own telehealth policy. Coverage and reimbursement for live video and store-and-forward may vary between MCOs.

“Telehealth is the use of electronic information and telecommunication technologies to support clinical care between an individual with mental illness and/or substance abuse issues and a healthcare practitioner.”

“Telehealth systems provide a live, interactive audio-video communication or videoconferencing connection between the individual in need of services and the crisis service delivery system.”


Telehealth 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 such provider is at a qualified site other than the site where the patient is located; and the patient is at a qualified site at a school clinic staffed by a healthcare services provider and equipped to engage in the telecommunications described in this section or a public elementary or secondary school staffed by a health care services provider and equipped to engage in the telecommunications described in this section and does not include audio only conversation; an electronic mail message or facsimile transmission.


Health insurance entities (including managed care organizations) participating in the medical assistance program are required to provide coverage for telehealth (which includes live video) delivered services in a manner that is consistent with the health insurance policy or contract provided for in-person services. Any provisions not stipulated in the telehealth services section of the insurance code shall be governed by the terms and conditions of the health insurance contract.

### Mental Health & Substance Abuse Services

TennCare will reimburse for live video for crisis-related services or an assessment for emergency admission by an in-patient psychiatric facility.


### Eligible Services / Specialties

- Mental Health & Substance Abuse Services

### Eligible Providers

No reference found.

### Eligible Sites

- Office of a healthcare services provider (an individual acting within the scope of a valid license issued pursuant to title 63 or any state-contracted crisis service provider employed by a facility licensed under title 33);
- A hospital licensed under title 68;
- A facility recognized as a rural health clinic under federal Medicare regulations;
- A federally qualified health center;
- A school clinic staffed or at a public elementary or secondary school appropriately staffed and equipped; or
- Any facility licensed under title 33, or any other location deemed acceptable by the health insurance entity.

*Source: TN Code Annotated, Title 56, Ch. 7, Part 1002(a)(4) & (6). (Accessed Sep. 2018).*

### Geographic Limits

Reimbursement and coverage must be provided for telehealth services 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.

*Source: TN Code Annotated. Title 56, Ch. 7, Part 1002(d)(2) & (e). (Accessed Sep. 2018).*

### Facility/Transmission Fee

No reference found.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Store-and-Forward</strong></td>
<td></td>
</tr>
<tr>
<td>Medicaid Managed Care plans must cover and reimburse for store-and-forward telemedicine services which are defined as:</td>
<td></td>
</tr>
<tr>
<td>- Using asynchronous computer-based 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</td>
<td></td>
</tr>
<tr>
<td>- The transferring of medical data from one (1) site to another through the use of a camera or similar device that records or stores an image that is sent or forwarded via telecommunication to another site for consultation.</td>
<td></td>
</tr>
<tr>
<td><strong>Source:</strong> TN Code Annotated, Title 56, Ch. 7, Part 1002(d)(2) &amp; (e). (Accessed Sep. 2018).</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health &amp; Substance Abuse Services</strong></td>
<td></td>
</tr>
<tr>
<td>TennCare will not reimburse for store-and-forward based upon definition of “telehealth systems” which describes it as “live interactive video”.</td>
<td></td>
</tr>
<tr>
<td><strong>Eligible Services/Specialties</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Geographic Limits</strong></td>
<td></td>
</tr>
<tr>
<td>Reimbursement and coverage must be provided for telehealth services 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.</td>
<td></td>
</tr>
<tr>
<td><strong>Source:</strong> TN Code Annotated, Title 56, Ch. 7, Part 1002(d)(2) &amp; (e). (Accessed Sep. 2018).</td>
<td></td>
</tr>
<tr>
<td><strong>Transmission Fee</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Remote Patient Monitoring</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td></td>
</tr>
</tbody>
</table>

### Conditions

No reference found.

### Remote Patient Monitoring

No reference found.

### Provider Limitations

No reference found.

### Other Restrictions

No reference found.

### Email / Phone / Fax

- No reimbursement for telephone.
- No reimbursement for fax.
- No reimbursement for email.

**Source:** TN Code Annotated, Title 56, Ch. 7, Part 1002(a)(6)(B).

### Consent

The patient must be informed and given an opportunity to request an in-person assessment before receiving a telehealth assessment.

This consent must be documented in the patient’s record.


### Out of State Providers

No reference found.
<table>
<thead>
<tr>
<th>Private Payer Laws</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definitions</strong></td>
</tr>
<tr>
<td>Telehealth means the use of real-time interactive audio, video telecommunications or electronic technology, or store-and-forward telemedicine services by a healthcare provider to deliver healthcare services to a patient within the scope of practice of the healthcare services provider when such provider is at a qualified site other than the site where the patient is located; and the patient is at a qualified site or at a school clinic staffed by a healthcare services provider and equipped to engage in the telecommunications described in this section or a public elementary or secondary school staffed by a health care services provider and equipped to engage in the telecommunications described in this section and does not include audio only conversation; an electronic mail message or facsimile transmission.</td>
</tr>
<tr>
<td><strong>Source:</strong> TN Code Annotated, Title 56, Ch. 7, Part 1002.</td>
</tr>
</tbody>
</table>

| **Requirements** |
| A health insurance entity shall provide coverage for healthcare services provided during a telehealth encounter in a manner that is consistent with what the health insurance policy or contract provides for in-person encounters for the same service. |
| Private payers are only required to reimburse for telehealth when the patient is located at a qualified site or a school clinic. Insurers may decide to reimburse for additional sites but are not required to. |
| A health insurance entity cannot exclude from coverage, a healthcare service solely because it is provided through telehealth and is not provided through an in-person encounter. |
| **Source:** TN Code Annotated, Title 56, Ch. 7, Part 1002, (Accessed Sep. 2018). |

| **Parity** |
| **Service Parity** |
| Health insurance entities (including managed care organizations) participating in the medical assistance program are required to provide coverage for telehealth (which includes live video) delivered services in a manner that is consistent with the health insurance policy or contract provided for in-person services. |
| **Source:** TN Code Annotated, Title 56, Ch. 7, Part 1002, (Accessed Sep. 2018). |
### Private Payer Laws

<table>
<thead>
<tr>
<th>Parity</th>
<th>Payment Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance entities are required to reimburse for the diagnosis, consultation, and treatment of an insured patient for a healthcare service covered under a health insurance policy or contract provided through telehealth without distinction of the geographic location or any federal, state, or local designation, or classification of the geographic area where the patient is located. The reimbursement is not required to exceed the cost of reimbursement for the same service provided in-person.</td>
<td></td>
</tr>
<tr>
<td>Out-of-network providers providing healthcare services through telehealth must be reimbursed under the same policies applicable to other out-of-network healthcare service providers.</td>
<td></td>
</tr>
<tr>
<td>A health insurance entity is 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.</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** TN Code Annotated, Title 56, Ch. 7, Part 1002. (Accessed Sep. 2018).

### Definitions

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. Telemedicine is not an audio only telephone conversation, email/instant messaging conversation or fax. It typically involves the application or 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.


### Consent

No reference found.

### Online Prescribing

Prior to online or telephone prescribing, providers must document and:

- Perform an appropriate history and physical examination;
- Make a diagnosis, consistent with good medical care;
- Formulate a therapeutic plan and discuss it with the patient;
- Ensure the availability for appropriate follow-up care.


A physician-patient relationship can be established via telemedicine with or without a facilitator present. Certain conditions apply in each case. See rule for details.


Tennessee adopted the Nurses Licensure Compact.


Tennessee adopted the Physical Therapy Compact.


Tennessee may issue telemedicine licenses to board-certified physicians from out of state (although not required to do so).

**Source:** TN Code Annotated Sec. 63-6-209(b).

The Tennessee Medical Board eliminated the telemedicine license. Individuals granted a telemedicine license under the former version of the rule may apply to have the license converted to a full license. Under certain circumstances individuals who do not convert to a full license can retain their telemedicine license.


The TN Osteopathic Board will still issue a telemedicine license.

**Source:** TN Rule Annotated, Rule 1050.02.17. (Accessed Sep. 2018).

Teledentistry means “the delivery of dental health care and patient consultation through the use of telehealth systems and technologies, including live, two-way interactions between a patient and a dentist licensed in this state using audiovisual telecommunication technology, or the secure transmission of electronic health records and medical data to a dentist licensed in this state to facilitate evaluation and treatment of the patient outside of a real-time or in-person interaction.”

Initial and subsequent examinations by dentists may be performed via teledentistry technology.


**Worker’s Compensation Reimbursement**

Payment shall be based on the Medicare guidelines and coding, with the exception of the geographic restrictions.

**Source:** TN Rule Annotated, 0800-2-17-.05. (Accessed Sep. 2018).
### Medicaid Program
**Texas Medicaid**

### Program Administrator
**Texas Health and Human Services Commission**

### Regional Telehealth Resource Center
**TexLa Telehealth Resource Center**

### Covers the States of
Louisiana and Texas

[http://www.texlatrc.org](http://www.texlatrc.org)

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Texas Medicaid reimburses for live video and store-and-forward in some circumstances. Home telemonitoring is reimbursable for some conditions when a provider is approved to deliver those services.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“Telehealth service”</strong> means a health service, other than a telemedicine medical service, that is delivered by a licensed or certified health professional acting within the scope of the health professional’s license or certification who does not perform a telemedicine medical service and that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including:</td>
</tr>
</tbody>
</table>

  - Compressed digital interactive video, audio, or data transmission;
  - Clinical data transmission using computer imaging by way of still-image capture and store-and-forward; and
  - Other technology that facilitates access to health care services or medical specialty expertise. |

**Source:** TX Admin. Code, Title 1 Sec. 354.1430(10) & TX Medicaid Telecommunication Services Handbook, pg. 9, (Accessed Sept. 2018).

<table>
<thead>
<tr>
<th>Telemedicine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telemedicine is defined as a health-care service that is either initiated by a physician who is licensed to practice medicine in Texas or provided by a health professional who is acting under physician delegation and supervision. Telemedicine is provided for the purpose of the following:</strong></td>
</tr>
</tbody>
</table>

  - Client assessment by a health professional
  - Diagnosis, consultation or treatment by a physician
  - Transfer of medical data that requires the use of advanced telecommunications technology, other than telephone or facsimile, including the following: (1) Compressed digital interactive video, audio or data transmission, (2) clinical data transmission using computer imaging by way of still-image and store-and-forward; and (3) Other technology that facilitates access to health-care services or medical specialty expertise. |

**Source:** TX Admin. Code, Title 1 Sec. 354.1430(10) & TX Medicaid Telecommunication Services Handbook, pg. 5, (Accessed Sept. 2018).
“Telemedicine medical service” means a health care service that is initiated by a physician or provided by a health professional acting under physician delegation and supervision, that is provided for purposes of patient assessment by a health professional, diagnosis or consultation by a physician, or treatment, or for the transfer of medical data, and that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including:

- Compressed digital interactive video, audio, or data transmission;
- Clinical data transmission using computer imaging by way of still-image capture and store-and-forward; and
- Other technology that facilitates access to health care services or medical specialty expertise.


“Telemedicine medical service” means a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician’s or health professional’s license to a patient at a different location than the physician or health professional using telecommunications or information technology.


Home telemonitoring is "a health service that requires scheduled remote monitoring of data related to a patient’s health and transmission of the data to a licensed home health agency or a hospital".


Telemedicine medical services are defined as healthcare services delivered by a physician licensed in Texas; and health care services delivered by a health professional acting within the scope of the physician’s or health professional’s license to a patient at a different location than the physician or health professional using telecommunications or information technology.

Telehealth services are defined as health-care services, other than telemedicine medical services, delivered by a health professional licensed, certified or otherwise entitled to practice in Texas and acting within the scope of the health professional’s license, certification or entitlement to a patient at a different physical location other than the health professional using telecommunications or information technology.


Synchronous audiovisual interaction is reimbursable under Texas Medicaid.


Provider reimbursement for telemedicine services must be in the same manner as in-person services.


Telemedicine: Texas health and human services agencies that administer a part of Medicaid are required to provide Medicaid reimbursement for a telemedicine service initiated or provided by a physician. Reimbursement is provided only for a telemedicine medical service initiated or provided by a physician.

Telemedicine services may not be required if an in-person consultation with a physician is reasonably available where the patient resides or works.

Telemedicine providers must make a good-faith effort to identify and coordinate with existing providers, to preserve and protect existing health care systems and medical relationships in an area.
With patient consent, the primary care provider must be notified of the telemedicine medical service for the purpose of sharing medical information. The notification must include a summary of the service, including exam findings, prescribed or administered medications, and patient instructions. If the patient is seen in a school-based setting and does not have a primary care provider, the patient’s parent or legal guardian must receive the notification.

Medicaid reimbursement is provided to a physician for a telemedicine medical service provided by the physician, even if the physician is not the patient’s primary care physician or provider, if:

- The physician is an authorized health care provider under Medicaid;
- The patient is a child who receives the services in a primary or secondary school-based setting;
- The parent or legal guardian of the patient provides consent before the services is provided; and
- A health professional is present with the patient during the treatment.


For new conditions, the patient site presenter must be readily available (in the same room or in a proximity determined by the professional providing the telemedicine service) on site at the established medical site to assist with care. Patient site presenter not required for mental health services (except in cases of behavioral emergencies).


See provider manual for special rules for Texas Health Steps program.

Telehealth: Before receiving a telehealth service, the patient must receive an initial evaluation for the same diagnosis or condition by a physician or other qualified healthcare professional licensed in Texas which can be performed in-person or as a telemedicine visit that conforms to 22 TAC Ch. 174. A patient receiving telehealth services must be evaluated annually by a physician or other healthcare professional (in-person or via a telemedicine visit) to determine if the patient has a continued need for the service. Exception for patients receiving telehealth services to treat a mental health diagnosis or condition.


Telemedicine
Texas Medicaid reimburses for live video for the following services provided through telemedicine:

- Consultations;
- Office or other outpatient visits;
- Psychiatric diagnostic interviews;
- Pharmacologic management;
- Psychotherapy;
- Data transmission;
- Supportive encounters for persons with intellectual disabilities or related conditions.


Telehealth
Texas Medicaid reimburses for live video for codes specified in the TX Medicaid Provider Procedures Manual. See individual manuals for reimbursable services provided through telehealth.

More than one medically necessary telemedicine or telehealth service may be reimbursed for the same date and same place of service if the services are billed by providers of different specialties.

Medicaid Telehealth Reimbursement

Telemedicine eligible distant site providers:

- Physician
- Certified Nutrition Specialist (CNS)
- Nurse Practitioner (NP)
- Advanced Practice Registered Nurse (APRNs)
- Physician Assistant (PA)
- Certified Nurse Midwife (CNM)

A distant site provider is the physician, or PA, NP or CNS who is supervised by and has delegated authority from a licensed Texas physician who uses telemedicine to provide health care services in Texas. Hospitals may also serve as the distant site provider.


Telehealth eligible distant site providers:

- Licensed professional counselors
- Licensed marriage and family therapist (LMFT)
- Licensed clinical social worker (LCSW)
- Licensed psychologist
- Licensed psychological associate
- Provisionally licensed psychologist
- Licensed dietician
- Durable medical equipment suppliers


A distant site provider is a physician, physician assistant, nurse practitioner, or clinical nurse specialist who is supervised and has delegated authority from a licensed Texas physician.


Telemedicine/Telehealth eligible originating (patient) sites:

- An established medical site
- A state mental health facility
- State supported living centers.

A patient’s home is not an established medical site, except when services are limited to mental health services delivered through telemedicine. For medical services the following requirements must be met to be provided in the clients’ home:

- A patient site presenter is present
- There is a defined physician-client relationship
- The technology is adequate to allow for a real time physical exam
- The physical exam is held to the same standards as in the traditional medical setting.


TX Medicaid is required to reimburse school districts or open enrollment charter schools for telehealth services delivered by a health professional even if the specialist is not the patient’s primary care provider if the school district or charter school is an authorized health care provider under Medicaid and the parent or guardian of the patient consents.
Medicaid Telehealth Reimbursement

A health professional is defined as:

- Licensed social worker, occupational therapist or speech language pathologist
- Licensed professional counselor
- Licensed marriage and family therapist
- Licensed specialist in school psychology.

Source: TX Government Code Sec. 531.02171.

Services may take place in a school-based setting if:

- The physician is an authorized health care provider under Medicaid;
- The patient is a child who receives the service in a primary or secondary school-based setting;
- The parent or legal guardian of the patient provides consent before the service is provided; and
- A health professional is present with the patient during treatment.

Source: TX Bill HB 1878(2015); TX Admin. Code, Title 1, Sec. 355.7001; & TX Admin. Code, Title 1, Sec. 354.1432. (Accessed Sept. 2018).

A patient’s home may be the patient site for telemedicine medical services or telehealth services. Patient site presenters must be enrolled in Texas Medicaid to be eligible for reimbursement for the patient site facility fee for telemedicine medical services.

The use of telemedicine medical services within intermediate care facilities for individuals with intellectual disabilities and/or State Supported Living Centers is subject to the policies established by HHSC.


Other Sites

For telemedicine medical services that are provided at a site other than an established medical site, the following apply:

- Patient-site presenters are not required for pre-existing conditions previously diagnosed by a physician through a face-to-face visit
- All clients must be seen by a physician for an in-person evaluation at least once a year
- Telemedicine medical services may not be used to treat chronic pain with scheduled drugs

A distant site provider may treat an established client’s new symptoms that are unrelated to the patient’s pre-existing condition, however the client must be advised to see a physician face-to-face within 72 hours. They cannot continue to be treated if they have not seen a physician within 72 hours.

A distant site provider who provides telemedicine services at a site other than an established medical site for a previously diagnosed medical condition must:

- See the client one time in a face-to-face visit before providing telemedicine medical care.
- See the client without an initial face-to-face visit as long as the client has received an in-person evaluation by another physician who has referred the client for additional care and the referral is documented in the medical record.


No reference found.
Telemedicine patient site locations are reimbursed a facility fee. It is not a benefit if the patient location is the client’s home.


There is distant-site physician reimbursement for assessment and evaluation office visit if the medical condition, illness, or injury for which the patient is receiving the service is not likely, within a reasonable degree of medical certainty, to undergo material deterioration within the 30-day period following the visit.

Source: TX Govt. Code Sec. 531.0217(c-1).

Patient site providers must be enrolled in Texas Medicaid to be eligible for reimbursement for the patient site facility fee.

Asynchronous store-and-forward technology, including asynchronous store-and-forward technology in conjunction with synchronous audio interaction between the distant site provider and the patient in another location is reimbursable under Texas Medicaid. The distant site provider would need to use one of the following:

- Clinically relevant photographic or video images, including diagnostic images
- The patient’s relevant medical records, such as medical history, laboratory and pathology results, and prescriptive histories
- Other forms of audiovisual telecommunication technologies that allow the distant site provider to meet the in-person visit standard of care


TX Medicaid Manual states that telemedicine and telehealth services only “involve direct face-to-face interactive video communication between the client and the distant-site provider.”


TX Administrative Code the Medicaid Telecommunications Services Handbook include definitions of “Telemedicine Medical Service,” “Telehealth Services” and “Telemedicine” which encompasses store-and-forward, stating that it includes “clinical data transmission using computer imaging by way of still-image capture and store-and-forward”.


Provider reimbursement must be the same as in-person services.


No reference found.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote Patient Monitoring</td>
</tr>
<tr>
<td>Policy</td>
</tr>
</tbody>
</table>

Texas Medicaid will reimburse for home telemonitoring in the same manner as their other professional services provided by a home health agency.


Online evaluation and management for home telemonitoring services is a benefit in the office or outpatient hospital setting when services are provided by a nurse practitioner, clinical nurse specialist, physician assistant or physician provider.

Scheduled periodic reporting of client data is required by a registered nurse, nurse practitioner, clinical nurse specialist, or physician assistant who is responsible for reporting data to the prescribing physician even when there have been no readings outside the parameters established in the physician’s orders.

The procedure code is limited to once per seven days.

Scheduled periodic reporting of client data to the physician is required.

Setup and daily monitoring is reimbursed when provided by a home health agency or outpatient hospital.

There must be prior authorization from TX Medicaid for home telemonitoring. Clients must be diagnosed with diabetes or hypertension and exhibit two or more risk factors (see regulations).


The home health agency must maintain extensive documentation in the patient’s medical record.

Daily home monitoring is a benefit when services are provided by a home health agency or an outpatient hospital and is available for up to 60 days per prior authorization request.


Notwithstanding any other law, providers may not receive reimbursement under Medicaid for the provision of home telemonitoring services on or after September 1, 2019.

### Medicaid Telehealth Reimbursement

#### Conditions

Home Telemonitoring is available only to patients who:

- Are diagnosed with diabetes, hypertension; or
- When it is determined by Texas Health and Human Services Commission to be cost effective and feasible the following conditions are also included: pregnancy, heart disease, cancer, chronic obstructive pulmonary disease, congestive heart failure, mental illness, asthma, myocardial infarction or stroke.

**Source:** TX Admin Code. Title 1, Sec. 354.1434 & TX Medicaid Telecommunication Services Handbook, pg. 9, & TX Government Code Sec. 531.02164. (Accessed Sept. 2018).

#### Provider Limitations

Providers must be enrolled and approved as home telemonitoring services providers.

**Source:** TX Admin Code. Title 1, Sec. 354.1434 & TX Medicaid Telecommunication Services Handbook, pg. 3 & 12, (Accessed Sept. 2018).

#### Other Restrictions

Patients that meet the condition criteria must exhibit two or more of the following risk factors:

- Two or more hospitalizations in the prior 12-month period;
- Frequent or recurrent emergency room admissions;
- A documented history of poor adherence to ordered medication regimens;
- A documented history of falls in the prior six-month period;
- Limited or absent informal support system;
- Living alone or being home alone for extended periods of time; and
- A documented history of care access challenges.


#### Email / Phone / Fax

- No reimbursement for email.
- No reimbursement for telephone.
- No reimbursement for FAX.
- No reimbursement for chart review.


TX Medicaid managed care organizations are not required to provide reimbursement for telemedicine medical services that are provided through only synchronous or asynchronous audio interactions including telephone, email and facsimile, although they may optionally do so.

Written or verbal consent must be obtained to allow any other individual (besides the distant site provider, patient site presenter or representative) to be present during a telemedicine or telehealth visit.

A good faith effort must be made to obtain written acknowledgement of notification of privacy practices, when communicating via email or other electronic method.

Before providing services, distant site providers who use telemedicine medical services must give their clients notice regarding telemedicine medical services, including the risks and benefits of being treated via telemedicine, how to receive follow-up care or assistance in the event of an adverse reaction to the treatment or in the event of an inability to communicate as a result of a technological or equipment failure. A signed and dated notice, including an electronic acknowledgment, by the client establishes a presumption of notice.

**Source:** TX Medicaid Telecommunication Services Handbook, pg. 5-6 (Accessed Sept. 2018).

The distant site must obtain informed consent.

A parent must provide written or verbal consent to the distant site provider to allow any other individual, other than the health professional as required by Texas Government Code §531.0217(c-4)(4) for school-based telemedicine medical services, to be physically present in the distant or patient site environment during a telemedicine medical service with a child.


An out-of-state physician who is a distant site provider may provide episodic telemedicine medical services without a Texas medical license as outlined in Texas Statute and Regulation.

Distant site providers that provide mental health services must be appropriately licensed or certified in Texas or be a qualified mental health professional community services (QMP-CS).


Telemedicine medical services provided at an established medical site may be used for all client visits, including evaluations to establish a defined physician-client relationship between a distant site provider and a client.

**Source:** TX Medicaid Telecommunication Services Handbook, pg. 7 (Accessed Sept. 2018).

**Children’s Health Insurance Program**

Allows reimbursement for live video telemedicine and telehealth services to children with special health care needs.

**Source:** TX Govt. Code Sec. 531.02162. (Accessed Sept. 2018).

Must use the “95” modifier for telemedicine/telehealth services (except for services that already indicate remote delivery in the description). See manual for codes that can be billed with the “95” modifier.

**Source:** TX Medicaid Telecommunication Services Handbook, pg. 6 (Accessed Sept. 2018).

The software system used by the distant site and originating site (when patient presenter is used) must allow secure authentication of the distant site provider and the client.

See provider manual for other information security and documentation requirements.

**Source:** TX Medicaid Telecommunication Services Handbook, pg. 5 (Accessed Sept. 2018).
Fees for telemedicine, telehealth and home telemonitoring services are adjusted within available funding.


Telehealth eligible originating site presenter:

- An individual who is licensed or certified in Texas to perform health care services
- A qualified mental health professional

A telepresenter is required at the originating site for both telemedicine and telehealth, unless the services relate to mental health. In that situation a patient-site presenter does not have to be readily available unless the client is in a danger to himself/herself or others.


A valid practitioner-patient relationship must exist between the distant site provider and patient. The relationship exists if the distant site provider meets the same standard of care required for an in-person service. A relationship is established through in-person services, through telemedicine medical services that meets the delivery modality requirements in TX Occupations Code Sec. 111.005(a)(3); or through the current telemedicine medical service. The relationship can be established through a call coverage agreement established in accordance with the Texas Medical Board rules.

Distant site providers should provide patients with written notification of the physician’s privacy practices as well as guidance on appropriate follow-up care.

A distant site provider may issue a valid prescription as part of a telemedicine medical service. If it is for a controlled substance, further requirements apply.

All patient health information generated or utilized during a telemedicine medical service must be stored by the distant site provider in a patient health record. If the distant site provider stores the patient health information in an electronic health record, the provider should use software that complies with Health Insurance Portability and Accountability Act (HIPAA) confidentiality and data encryption requirements, as well as with HHS rules implementing HIPAA.

Documentation for a service provided via telemedicine must be the same as for a comparable in-person service.

If a patient has a primary care provider who is not the distant site provider and the patient or their parent or legal guardian provides consent to a release of information, a distant site provider must provide the patient’s primary care provider with the following information:

- A medical record or report with an explanation of the treatment provided by the distant site provider
- The distant site provider’s evaluation, analysis, or diagnosis of the patient

Unless the telemedicine medical services are rendered to a child in a school-based setting, distant site providers of mental health services are not required to provide the patient’s primary care provider with a treatment summary. For telemedicine medical services provided to a child in a school-based setting, a notification provided by the telemedicine medical services physician to the child’s primary care provider must include a summary of the service, exam findings, prescribed or administered medications, and patient instructions.

“Telehealth service” means a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional’s license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

“Telemedicine medical service” means a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician’s or health professional’s license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.


Each issuer of a health benefit plan must adopt and display in a conspicuous manner on their website the policies and payment practices for telemedicine medical services and telehealth services. They, however, are not required to list payment rates.


Worker’s Compensation

A health care provider must bill for telemedicine and telehealth services according to Medicare payment policies as defined in Section 134.203 in the Texas Administrative Code; and provisions of the Texas Administrative Code, Insurance Title. A health care provider may bill and be reimbursed for telemedicine or telehealth services regardless of where the injured employee is located at the time the telemedicine or telehealth services are provided.


Prohibits a health benefit plan from excluding from coverage a service delivered as a telemedicine medical service or a telehealth service solely because the service is not provided in-person. A health plan is not required to provide coverage for services provided by only synchronous or asynchronous audio interaction including audio-only telephone; email or facsimile.


A health plan may require a deductible, a copayment, or coinsurance for a covered health care service or procedure delivered as a telemedicine medical service or a telehealth service, however the amount of the deductible, copayment or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for the same service provided through an in-person consultation.

Source: TX Insurance Code Sec. 1455.00(b)4. (Accessed Sept. 2018).
Telehealth service means a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional’s license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine service means a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician’s or health professional’s license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.


Speech-Language Pathology and Audiology
Telehealth is “the use of telecommunications and information technologies for the exchange of information from one site to another for the provision of speech-language pathology or audiology services to to a client from a provider.”

Telehealth services--The application of telecommunication technology to deliver speech-language pathology and/or audiology services at a distance for assessment, intervention, and/or consultation.

Telepractice--The use of telecommunications technology by a license holder for an assessment, intervention, or consultation regarding a speech-language pathology or audiology client.

Telepractice services--The rendering of audiology and/or speech-language pathology services through telepractice to a client who is physically located at a site other than the site where the provider is located.

Source: TX Admin. Code, Title 40 Ch. 16 Sec. 111.120. (Accessed Sept. 2018).

Occupational Therapy
Telehealth is a “mode of service delivery for the provision of occupational therapy services delivered by an occupational therapy practitioner to a client at a different physical location using telecommunications or information technology. Telehealth refers only to the practice of occupational therapy by occupational therapy practitioners who are licensed by this Board with clients who are located in Texas at the time of the provision of occupational therapy services. Also may be known as other terms including but not limited to telepractice, telecare, telerehabilitation, and e-health services.”


Consent
Consent required prior to telemedicine or telehealth services.

Either originating or distant site health professionals shall obtain this consent.

For a child receiving telemedicine services in a primary school-based setting, advance parent or legal guardian consent must be obtained.

A valid practitioner-patient relationship is present between a practitioner providing a telemedicine medical service and a patient receiving the telemedicine medical service as long as the practitioner complies with the same standard of care as would apply in an in-person setting, and complies with one of the following scenarios:

- Has a preexisting practitioner-patient relationship with the patient established;
- Communicates, regardless of the method of communication, with the patient pursuant to a call coverage agreement established in accordance with Texas Medical Board rules with a physician requesting coverage of medical care for the patient; or
- Provides the telemedicine medical services through the use of one of the following methods, as long as the practitioner complies with follow-up requirements and the method allows the practitioner to have access to the relevant clinical information that would be required to meet the standard of care.
  - Synchronous audiovisual interaction
  - Asynchronous store-and-forward technology, including in conjunction with synchronous audio interaction, as long as practitioner uses relevant clinical information from clinically relevant photographic or video images, or the patient’s relevant medical records
  - Another form of audiovisual telecommunication technology that allows the practitioner to comply with the appropriate standard of care

A practitioner who provides telemedicine medical services to a patient shall provide the patient with guidance on appropriate follow up care and with the patient’s consent, forward the report of the encounter to the patient’s primary care physician within 72 hours.

A practitioner-patient relationship is not present for purposes of prescribing an abortifacient or other drug or device to terminate a pregnancy.

The Texas Medical Board, Texas Board of Nursing, Texas Physician Assistant Board and the Texas Pharmacy Board are required to adopt joint rules that establish the determination of a valid prescription, which must allow for the establishment of the practitioner-patient relationship through telemedicine if it meets the standards outlined above.

This section does not apply to mental health services.


A valid prescription must be issued for a legitimate medical purpose and meet all other applicable laws before prescribing.

Treatment of chronic pain with scheduled drugs through use of telemedicine is prohibited unless otherwise allowed under federal and state law. Treatment of acute pain with scheduled drugs through telemedicine is allowed unless otherwise prohibited under federal and state law.

**Source:** TX Admin. Code, Title 22, Part 9, Ch. 174.5. (Accessed Sept. 2018).

Establishing a practitioner-patient relationship is not required for prescription of sexually transmitted disease for partners of the physician’s established patient, if the physician determines that the patient may have been infected; or drugs or vaccines for after close contact with an infectious disease.

**Source:** TX Admin. Code, Title 22, Part 9, Ch. 190.8(1)(L). (Accessed Sept. 2018).
A telemedicine license may be issued for out of state providers.

**Source:** TX Admin. Code, Title 22, Sec. 172.12 & TX Occupation Code Section 151.056. (Accessed Sept. 2018).

An out-of-state physician may provide episodic consultation without a TX medical license.

**Source:** TX Admin. Code, Title 22, Part 9, Ch. 174.

Texas adopted the Nurses Licensure Compact.


Texas adopted the Physical Therapy Compact.


### Professional Board Telehealth-Specific Regulations

- TX Medical Board (**Source:** TX Admin. Code, Title 22, Part 9, Ch. 174).
- TX Board of Speech Pathology and Audiology (**Source:** TX Admin. Code, Ch. 16 Sec. 111.120).
- TX Board of Occupational Therapy Examiners (**Source:** TX Admin. Code, Title 40, Ch. 372.1)

An e-Health Advisory Committee was established under TX Government Code Section 531.012 and is comprised of 15 members, including:

- At least one expert on telemedicine
- At least one expert on home telemonitoring services
- At least one representative of consumers of health services provided through telemedicine.

Medicaid Program: Utah Medicaid
Program Administrator: Utah Department of Health
Regional Telehealth Resource Center: Northwest Regional Telehealth Resource Center & Southwest Telehealth Resource Center
Northwest Regional TRC Covers the States of: Alaska, Idaho, Montana, Oregon, Utah, Washington, and Wyoming
Southwest Regional TRC Covers the States of: Arizona, Colorado, Nevada, New Mexico, and Utah
https://www.nrtrc.org
http://www.southwesttrc.org

Utah Medicaid reimburses for live video. Store-and-forward is not reimbursable as telehealth is required to be a “two-way, real time interactive connection.” Home telemetry for outpatient long-term cardiac monitoring is allowable with prior authorization under certain conditions.

Modifier GT is required.

Services with the GQ modifier (indicating asynchronous) is not covered.


Providers should use Place of Service code 02 when delivering services from a distance.


Telemedicine "is two-way, real-time interactive communication between the member and the physician or authorized provider at the distant site. This electronic communication uses interactive telecommunications equipment that includes, at a minimum, audio and video equipment."


Home Health Services
Telehealth or Telemedicine is a technological method of providing auditory and visual connection between the skilled home health care nurse at a Telehealth site and the patient living in a rural Utah area.

Providers are eligible for reimbursement under Utah’s Medical Assistance Program.


Utah Medicaid covers medically appropriate services delivered via telemedicine.

Limitations:

- Must be HIPAA compliant
- Must comply with Utah Health Information Network Standards for Telehealth


Covered services may be delivered by means of telemedicine, as clinically appropriate, including consultation, evaluation and management services, mental health services, substance use disorder services and telepsychiatric consultations. Must comply with Utah Health Information Network standards for telehealth.

The Department pays the lesser of the amount billed or the rate on the fee schedule.


Eligible services include but are not limited to:

- Consultation services
- Evaluation and management services
- Mental health services
- Substance use disorder services
- Telepsychiatric consultations

See manual for high level list of services that can be delivered via telemedicine.

Rural health clinic and federally qualified health clinic services may be delivered via telemedicine.


The Medicaid program is required to reimburse for personal mental health therapy office visits provided through telemedicine services and telepsychiatric consultations at a rate set by the Medicaid program (includes managed care plans). Also see Misc. section.


Telepsychiatric consultations between a physician and a board-certified psychiatrist are a covered service. See Medicaid Information Bulletin for specific CPT codes to bill.


Rural health clinic and federally qualified health clinic services may be delivered via telemedicine.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Eligible Sites</th>
<th>No reference found.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Geographic Limits</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
| Live Video | Facility/Transmission Fee | The provider at the originating site receives no additional reimbursement for the use of telemedicine.  
| Store-and-Forward | Policy | Utah Medicaid defines telemedicine as “two-way, real time interactive communication” excluding store-and-forward from the definition.  
<p>| | Eligible Services/Specialties | No reference found. |
| | Geographic Limits | No reference found. |</p>
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Store-and-Forward Transmission Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulletin indicates The Skilled Nursing Pilot Project has been removed from manual, however it is still listed in the Home Health Services manual, as of their last update in Aug. 2017. See Home Health Services Manual for details.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home telemetry for outpatient long-term cardiac monitoring is allowed with prior authorization. Criteria include:</td>
</tr>
<tr>
<td>• Must be ordered by a neurologist</td>
</tr>
<tr>
<td>• Member must have had a stroke or TIA with no identifiable cause</td>
</tr>
<tr>
<td>• Member should have already had 24-hour monitoring done previously</td>
</tr>
<tr>
<td>• Member should not be currently taking anti-coagulated or Warfarin for any other reason</td>
</tr>
<tr>
<td>• Member should not have a known contraindication for Warfarin</td>
</tr>
<tr>
<td>• Outpatient long-term cardiac monitoring may only be authorized for the 30-day test</td>
</tr>
<tr>
<td>• Data from the test must be reviewed and interpreted by a cardiologist</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only for patients with a long-term cardiac health issue.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test must be ordered by a neurologist and reviewed and interpreted by a cardiologist.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>
Private Payer Laws

Definitions

“Digital health service means the electronic transfer, exchange, or management of related data for diagnosis, treatment, consultation, educational, public health, or other related purposes.”

Source: UT Code, 26-9f-102.

“Telehealth services” means the transmission of health-related services or information through the use of electronic communication or information technology.

“Telemedicine services” means telehealth services including:

• Clinical care;
• Health education;
• Health administration;
• Home health; or
• Facilitation of self-managed care and caregiver support; and…

Must be provided by a provider to a patient through a method of communication that:

• Uses asynchronous store-and-forward transfer; or
• Uses synchronous interaction; and…

Meets industry security and privacy standards, including compliance with:

• The federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended; and
• The federal Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 226, 467, as amended.

Source: Utah Code, 26-60-102.
### Private Payer Laws

#### Requirements

All health insurance plans must disclose whether the insurer provides coverage for telehealth services in accordance with section 26-18-13.5 and terms associated with that coverage.

**Source:** UT Code 31A-22-613.5.

#### Recently Passed Legislation (Effective: Jan. 1, 2019)

A health benefit plan that offers coverage for mental health services shall:

- Provide coverage for telepsychiatric consultation during or after an initial visit between the patient and a referring in-network physician;
- Provide coverage for a telepsychiatric consultation from an out-of-network board certified psychiatrist if the consultant is not made available to a physician within seven business days after the initial request is made by an in-network provider; and
- Reimburse for the services at the equivalent of the in-network or out-of-network rate set by the benefit plan after taking into account cost-sharing that may be required under the health benefit plan.

An insurer can also meet the requirement to cover telepsychiatric consultation for a patient by providing coverage for behavioral health treatment (see statute for details).

**Source:** UT Code, 31A-22-647 (HB 139 – 2018).

<table>
<thead>
<tr>
<th>Parity</th>
<th>Service Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No service parity.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>
Before providing treatment or prescribing a prescription drug, provider must:

- Obtain and document patient’s relevant clinical history and current symptoms

Source: UT Code, 26-60-103.

Providers must first obtain information in the usual course of professional practice that is sufficient to establish a diagnosis, to identify conditions, and to identify potential risks to the proposed treatment.


An out-of-state physician may practice without a Utah license if:

- The physician is licensed in another state, with no licensing action pending and at least 10 years of professional experience;
- The services are rendered as a public service and for a noncommercial purpose;
- No fee or other consideration of value is charged, expected or contemplated, beyond an amount necessary to cover the proportionate cost of malpractice insurance;
- The physician does not otherwise engage in unlawful or unprofessional conduct.

Source: UT Code Annotated Sec. 58-67-305(7).

A mental health therapist licensed in another state and in good standing can provide short term transitional mental health therapy remotely if:

- The mental health therapist is present in the state where he/she is licensed;
- The client relocates to Utah, and was a client immediately before the relocation;
- The therapy or counseling is provided for a maximum of 45 days after the client relocates;
- Within 10 days of the client’s relocation, the mental health therapist provides a written notice to the Division of Occupational and Professional Licensing of their intent to provide therapy/counseling remotely; and
- The mental health therapist does not engage in unlawful or unprofessional conduct.


Utah adopted the Federation of State Medical Board (FSMB)’s model language for an interstate medical licensure compact.


Member of Psychology Interjurisdictional Compact.


Member of the Nurse Licensure Compact

Source: Nurse Licensure Compact.

If a hospital participates in telemedicine, it shall develop and implement policies governing the practice of telemedicine in accordance with the scope and practice of the hospital.

These policies shall address security, access and retention of telemetric data, and define the privileging of all health professionals who participate in telemedicine.

Vermont Medicaid reimburses for live video under certain circumstances. There is no reference to store-and-forward other than tele-dermatology and tele-ophthalmology are not reimbursable. Home health monitoring is considered a Medicaid benefit and is available under certain conditions.


Telemedicine is defined in Act 64 as “…the delivery of health care services…through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.”


“Telemedicine means the delivery of health care services such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that meets Health Insurance Portability and Accountability Act (HIPAA) requirements. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.”

**Source:** VT Statutes Annotated, Title 8 Sec. 4100k (2017).

Health insurance plans must provide coverage for health care service delivered through telemedicine by a health care provider at a distant site to a patient at an originating site to the same extent that the plan would cover the services if they were provided through in-person consultation.

An originating site is the location of the patient, whether or not accompanied by a health care provider, at the time services are provided by a health care provider through telemedicine, including a health care provider’s office, a hospital, or a health care facility, or the patient’s home or another nonmedical environment such as a school-based health center, a university-based health center or patient’s workplace.

A distant site is the location of the health care provider delivering services through telemedicine at the time the services are provided.

**Source:** VT Statutes Annotated, Title 8 Sec. 4100k & Title 18 Sec. 9361 (2017).

Live video is reimbursed for clinically appropriate services delivered through telemedicine outside a health care facility or from facility to facility.

Facilities providing live telemedicine services are required to use the GT modifier.

02 place of service code must be on all claims.

### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Live Video</th>
<th>Eligible Services / Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

A distant site is the location of the health care provider delivering services through telemedicine at the time the services are provided.

**Source:** VT Statutes Annotated, Title 8 Sec. 4100k & Title 18 Sec. 9361 (2017).

Must be a Medicaid-enrolled provider.

<table>
<thead>
<tr>
<th>Eligible Providers</th>
<th>Eligible Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>An originating site is the location of the patient, whether or not accompanied by a health care provider, at the time services are provided by a health care provider through telemedicine, including a health care provider’s office, a hospital, or a health care facility, or the patient’s home or another nonmedical environment such as a school-based health center, a university-based health center or patient’s workplace.</td>
</tr>
<tr>
<td></td>
<td><strong>Source:</strong> VT Statutes Annotated, Title 8 Sec. 4100k &amp; Title 18 Sec. 9361 (2017).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Geographic Limits</th>
<th>Facility/Transmission Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td>A facility fee is reimbursed, unless the facility site provider is employed by the same entity as the distant site provider.</td>
</tr>
</tbody>
</table>

The Department of Vermont Health Access is required to reimburse the health care provider at the distant site and the health care facility at the originating site for services rendered.

**Source:** VT Statutes Annotated, Title 8 Sec. 4100k No. 173 (2017).

<table>
<thead>
<tr>
<th>Store-and-Forward</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health plans (including Medicaid) are allowed but not required to reimburse for tele-ophthalmology and tele-dermatology.</td>
<td></td>
</tr>
<tr>
<td><strong>Source:</strong> VT Statutes Annotated, Title 8 Sec. 4100k. (2017).</td>
<td></td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td>Store-and-Forward</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td>Geographic Limits</td>
</tr>
<tr>
<td></td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Transmission Fee</td>
</tr>
<tr>
<td></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
| Conditions                       | Provider Limitations | Qualified providers are home health agencies enrolled with Vermont Medicaid. The following healthcare professionals can review data:  
  • Registered nurse  
  • Nurse practitioner  
  • Clinical nurse specialist  
  • Licensed practice nurse under supervision of RN  
  • Physician assistant  
### Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Remote Patient Monitoring</th>
<th>Other Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals receiving Medicaid telemonitoring must:</td>
<td></td>
</tr>
<tr>
<td>• Have Medicaid as primary insurance or be dually eligible with non-home bound status; and</td>
<td></td>
</tr>
<tr>
<td>• Have congestive heart failure; and</td>
<td></td>
</tr>
<tr>
<td>• Be clinically eligible for home health services; and</td>
<td></td>
</tr>
<tr>
<td>• Have a physician’s plan of care with an order for telemonitoring services.</td>
<td></td>
</tr>
</tbody>
</table>


### Email / Phone / Fax

<table>
<thead>
<tr>
<th>Email / Phone / Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reimbursement for email.</td>
</tr>
<tr>
<td>No reimbursement for telephone.</td>
</tr>
<tr>
<td>No reimbursement for FAX.</td>
</tr>
</tbody>
</table>


### Consent

<table>
<thead>
<tr>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

### Out of State Providers

<table>
<thead>
<tr>
<th>Out of State Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

### Miscellaneous

<table>
<thead>
<tr>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

### Private Payer Laws

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Telemedicine means the delivery of health care services such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that meets Health Insurance Portability and Accountability Act (HIPAA) requirements. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.”</td>
</tr>
</tbody>
</table>

**Source:** VT Statutes Annotated, Title 8 Sec. 4100k (2017).
# Private Payer Laws

**Requirements**

Health insurance plans must provide coverage for health care service delivered through telemedicine by a health care provider at a distant site to a patient at an originating site to the same extent that the plan would cover the services if they were provided through in-person consultation.

An originating site is the location of the patient, whether or not accompanied by a health care provider, at the time services are provided by a health care provider through telemedicine, including a health care provider’s office, a hospital, or a health care facility, or the patient’s home or another nonmedical environment such as a school-based health center, a university-based health center or patient’s workplace.

A distant site is the location of the health care provider delivering services through telemedicine at the time the services are provided.

*Source: VT Statutes Annotated, Title 8 Sec. 4100k & Title 18 Sec. 9361 (2017).*

A health plan may limit coverage to health care providers in a plan’s network. A health plan cannot impose limitations on the number of telemedicine consultations a covered person may receive that exceed limitations on in-person services. Health plans are not prohibited from limiting coverage to only services that are medically necessary and clinically appropriate for delivery through telemedicine, subject to the terms and conditions of the covered person’s contract.

*Source: VT Statutes Annotated, Title 8 Sec. 4100k & Title 18 Sec. 9361 (2017).*

**Parity**

For live video, plans are required to cover services provided through telemedicine to the same extent the plan covers services provided in-person. For store-and-forward, plans are allowed but not required to reimburse for tele-ophthalmology and tele-dermatology.

*Source: VT Statutes Annotated, Title 8 Sec. 4100k (2017).*

No explicit payment parity.

**Definitions**

“Telemedicine means the delivery of health care services such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that meets Health Insurance Portability and Accountability Act (HIPAA) requirements. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.”

*Source: VT Statutes Annotated, Title 8 Sec. 4100k (2017) & Title 18 Sec. 9361 (2017).*

**Consent**

A health care provider delivering health care services through telemedicine must obtain and document a patient’s oral or written informed consent.

*Source: VT Statutes Annotated, Title 18 Sec. 9361 (2017).*
### Professional Regulation/Health & Safety

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online Prescribing</td>
<td>Providers may prescribe, dispense, or administer drugs or medical supplies, or otherwise provide treatment recommendations if they first examine the patient in-person or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically. Treatment recommendations made via electronic means, including issuing a prescription via electronic means, shall be held to the same standards of appropriate practice as those in traditional provider-patient settings.</td>
<td>VT Statutes Annotated, Title 18 Sec. 9361 (2017).</td>
</tr>
<tr>
<td>Cross-State Licensing</td>
<td>Vermont enacted the Interstate Medical Licensure Compact.</td>
<td>VT Act No. 115 (S. 253).</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>No reference found.</td>
<td></td>
</tr>
</tbody>
</table>
Virginia Medicaid reimburses for live video, store-and-forward, and remote patient monitoring under certain circumstances. Plans participating in the Medicare-Medicaid Demonstration Waiver are permitted to use store-and-forward and remote patient monitoring in rural and urban locations and to provide reimbursement for services.

**Definitions**

"Telemedicine is the real-time or near real-time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment."


"Telemedicine is the real-time or near real-time exchange of information for the purposes of diagnosis and treatment."


Telemedicine service providers provide real-time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment.


**Medicaid-Medicare Waiver**

"Telehealth" or "telemedicine" means the real-time or near real-time two-way transfer of data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment.


**Live Video**

Reimbursement is provided subject to coverage requirements.

Eligible services:

- Evaluation and management
- Psychiatric care
- Specialty medical procedures
- Speech therapy
- Radiology service and procedures


Speech therapy is reimbursable for a speech-language pathologist at a remote location and a qualified school aide with the child during a tele-practice session.


Eligible providers:

- Physicians
- Nurse practitioners
- Nurse midwives
- Psychiatrist
- Psychiatric clinical nurse specialist
- Psychiatric nurse practitioner
- Marriage and family therapist/counselor
- School psychologist
- Substance abuse practitioner
- Clinical nurse specialists
- Clinical psychologists
- Clinical social workers
- Local Education Agency (billing speech therapy)
- Providers must have appropriate license from the Department of Behavioral Health and Developmental Services and be enrolled with Magellan


Eligible originating sites locations:

- Provider offices
- Local Education Agency
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospitals
- Nursing Facilities
- Health Department Clinics
- Renal Units
- Community Services Boards
- Residential Treatment Centers

All listed providers are also considered eligible originating site providers.

### Medicaid Telehealth Reimbursement

#### Geographic Limits

Physicians may be physically located outside of VA but must be located within the continental US to deliver telemedicine services. Telemedicine out-of-state coverage does not include other out-of-state providers such as nurse practitioners.


#### Live Video

Reimburses a facility fee.


#### Facility/Transmission Fee

DMAS reimburses for diabetic retinopathy screening through telemedicine for Medicaid members with Type 1 or 2 diabetes. Radiology related procedures are also included under telemedicine coverage as well as certain codes for teledermatology.


**Medicare-Medicaid Demonstration Waiver:**

Participating plans shall be permitted to use telehealth in rural and urban settings and reimburse for store-and-forward applications.


#### Store-and-Forward

Services covered include:

- Radiology and radiology procedures
- Diabetic retinopathy (regardless of the number of fields viewed for all Medicaid Members with Type 1 or Type 2 diabetes)
- Outpatient teledermatology


#### Eligible Services/Specialties

Physicians may be physically located outside of VA but must be located within the continental US to deliver telemedicine services. Telemedicine out-of-state coverage does not include other out-of-state providers such as nurse practitioners.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Store-and-Forward</th>
<th>Transmission Fee</th>
<th>Policy</th>
<th>Conditions</th>
<th>Provider Limitations</th>
<th>Other Restrictions</th>
<th>Email / Phone / Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimburses a facility fee.</td>
<td></td>
<td></td>
<td>VA Medicaid reimburses for Continuous Glucose Monitoring.</td>
<td>Coverage is limited to members with Type 1 diabetes, or Type 2 diabetes (when over 16 years old), or pregnant women who are injecting insulin with either Type 1 or 2. Service authorization is required. Additional requirements apply.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX.</td>
</tr>
</tbody>
</table>
### Out of State Providers

Out-of-state physicians must enroll with DMAS contractors to utilize telemedicine in the Medicaid program.


Providers must be licensed in Virginia and enrolled in the state Medicaid program in which they practice medicine. The provider must also hold a Virginia Department of Health Professional license to provide telemedicine services.


Physicians may be physically located outside of VA but must be located within the continental US to deliver telemedicine services. Telemedicine out-of-state coverage does not include other out-of-state providers such as nurse practitioners.


### Miscellaneous

Use of telemedicine must be noted in the service documentation of the patient record.

The originating site provider or designee must attend the encounter with the member, unless the encounter documentation in the patient record notes the reason staff was not present.


Telemedicine also available in the Governor’s Access Plan for the Seriously Mentally Ill (GAP).


For mental health clinics, providers intending to bill telemedicine services must first notify DMAS. This is a one-time activity and needs to occur at least 10 days in advance.


**Dual Eligibles (Medicare and Medicaid)**

DMAS established the Commonwealth Coordinated Care program and allows participating plans to reimburse for telehealth for Medicare and Medicaid services as an innovative way to reduce hospital readmissions, reduce ED visits, etc. Participating plans shall encourage the use of telehealth to promote community living and improve behavioral health services. Plans shall be permitted to use telehealth in rural and urban settings and reimburse for store-and-forward. Plans shall also have the ability to cover remote patient monitoring.

*Source:* 12VAC30-121-70.
## Private Payer Laws

### Definitions

Telemedicine 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.

**Source:** VA Code Annotated Sec. 38.2-3418.16.

### Requirements

An insurer shall not exclude a service for coverage solely because the service is provided through telemedicine services.

**Source:** VA Code Annotated Sec. 38.2-3418.16 (2012).

Facility fee reimbursement is allowed, but not required.

**Source:** VA Code Annotated Sec. 38.2-3418.16 (2012).

### Parity

The treating provider or consulting provider must be reimbursed on the same basis that the insurer is responsible for coverage for the provision of services face-to-face.

**Source:** VA Code Annotated Sec. 38.2-3418.16 (2012).

### Professional Regulation/Health & Safety

### Definitions

Telemedicine 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.

**Source:** VA Code Annotated Sec. 38.2-3418.16 & Sec. 54.1-3303.

### Consent

Informed consent must be obtained and maintained.

**Source:** Telemedicine Guidance. Doc. # 85-12. VA Board of Medicine.
### Online Prescribing

Practitioners prescribing controlled substances must have a “bona fide” relationship with the patient.

**Requirements:**
- Obtaining a medical or drug history;
- Informing the patient about the benefits and risks of the drug;
- Conducting a patient exam, either physically or by the use of instrumentation and diagnostic equipment, through which images and medical records may be transmitted electronically.

Practitioners can also prescribe Schedule II-V controlled substances under certain circumstances. Additional requirements apply for the prescription of Schedule VI controlled substances via telemedicine.

**Source:** VA Code Annotated Sec. 54.1-3303.

### Cross-State Licensing

**Member of the Nurses Licensure Compact.**


### Miscellaneous

**Telemedicine Guidance from VA Medical Board**

- Prescribing via telemedicine is at the discretion of the prescribing practitioner.
- Informed consent must be obtained and maintained.
- See guidance for additional requirements.

**Source:** Telemedicine Guidance. Doc. # 85-12. VA Board of Medicine.

The Center for Telehealth of the University of Virginia and the Virginia Telehealth Network will establish a telehealth pilot program to expand access to and improve the coordination and quality of health care services in rural and medically underserved areas of the Commonwealth through the use of telemedicine services, for the purpose of providing access to health care services that would not be available to individuals in rural and medically underserved areas of the Commonwealth without the use of telehealth technology.

**Source:** VA Senate Bill 369. (2016).
Medicaid Program: Washington Apple Health
Program Administrator: Washington State Health Care Authority
Regional Telehealth Resource Center: Northwest Regional Telehealth Resource Center
https://www.nrtrc.org

Summary


Client must be present and participating in telemedicine visit. Clients under the Family Planning, TAKE CHARGE, First Steps, and School Based Health Care Service program are also eligible for telemedicine through fee-for-service.

For patients with managed care plan coverage, telehealth services will not be reimbursed separately. All services must be arranged and provided by primary care providers. It is not mandatory that the plan pay for telehealth services.


Telemedicine is covered by the Department.

Source: WA Admin. Code Sec. 182-531-0100.

Definitions

“Telemedicine is when a health care practitioner uses HIPAA-compliant interactive real-time audio and video telecommunications (including web-based applications) or store-and-forward technology to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located.”


Home Health Services

“Telemedicine means the use of tele-monitoring to enhance the delivery of certain home health skilled nursing services through:

- The collection of clinical data and the transmission of such data between a patient at a distant location and the home health provider through electronic processing technologies. Objective clinical data that may be transmitted includes, but is not limited to, weight, blood pressure, pulse, respirations, blood glucose, and pulse oximetry;
- The provision of certain education related to health care services using audio, video, or data communication instead of a face-to-face visit.”

Live video is covered for patients with fee-for-service coverage when it is medically necessary. The referring provider is responsible for determining and documenting medical necessity.


Applied Behavior Analysis (ABA) for Clients Age 20 and Younger
Eligible telemedicine services:

- Program supervision when the child is present
- Family training, which does not require the child’s presence

See ABA fee schedule for telemedicine billing instructions.


Behavioral Health
Behavioral health organizations who have a contract with the department shall reimburse a provider for behavioral health services provided to a covered person who is under 18 years old through telemedicine or store-and-forward if:

- The organization provides coverage for behavioral health services when provided in-person; and
- The service is medically necessary

Source: Revised Code of WA Sec. 71.24.335.

Teledentistry
Teledentistry can be delivered through a synchronous or asynchronous method. The agency covers teledentistry as a substitute for an in-person, face-to-face, hands-on encounter when medically necessary.

A dentist or authorized dental provider may delegate allowable tasks to dental hygienists and Expanded Function Dental Assistants through teledentistry. Delegation of tasks must be under general supervision.

See manual for acceptable CPT codes.


Rural Health Clinics (RHCs)
RHCs are not authorized to serve as a distant site for telemedicine consultations.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Originating Sites</strong></td>
</tr>
<tr>
<td>• Clinics;</td>
</tr>
<tr>
<td>• Dental offices;</td>
</tr>
<tr>
<td>• Home or any location determined appropriate by the individual receiving the service;</td>
</tr>
<tr>
<td>• Hospitals—inpatient or outpatient;</td>
</tr>
<tr>
<td>• Neurodevelopmental centers;</td>
</tr>
<tr>
<td>• Schools;</td>
</tr>
<tr>
<td>• Rural health clinic;</td>
</tr>
<tr>
<td>• Federally qualified health center;</td>
</tr>
<tr>
<td>• Physician’s or other health care provider’s office;</td>
</tr>
<tr>
<td>• Community mental health center/chemical dependency settings;</td>
</tr>
<tr>
<td>• Skilled nursing facility; or</td>
</tr>
<tr>
<td>• Renal dialysis center (included in statute, and administrative code, but not in provider manual)</td>
</tr>
</tbody>
</table>


Originating site providers are responsible for determining and documenting that telemedicine is medically necessary.

When the originating site is a school, the school district must submit a claim on behalf of both the originating and distant site.

**Source:** WA State Health Care Authority, Medicaid Provider Guide, School Based Health Care Services, p. 27 (Jan. 1, 2018) (Accessed Sep. 2018).

Originating sites may not distinguish between rural and urban originating sites.

**Source:** Revised Code of WA Sec. 41.05700 & Admin Code 182-531-1730.

Facility fees for originating sites, except inpatient hospitals.

Medicaid Telehealth Reimbursement

**Policy**

Washington Medicaid reimburses for some store-and-forward services.


WA Medicaid pays for store-and-forward when all of the following conditions are met:

- There is an associated office visit that can be done either in-person or via asynchronous telemedicine.
- The transmission of information is HIPAA compliant.
- Written informed consent is obtained.

If the consultation results in a face-to-face visit in-person or via telemedicine with the specialist within 60 days of the store-and-forward consult, the agency does not pay for the consult.


**Eligible Services/Specialties**

WA Apple Health pays for store-and-forward for teledermatology. Teledermatology services via store-and-forward must be billed with GQ modifier and 02 POS Code from the distant site. The sending provider bills as usual with the E&M code and no modifier.

See manual for acceptable CPT/HCPCS codes.


**Teledentistry**

Teledentistry can be delivered through a synchronous or asynchronous method. The agency covers teledentistry as a substitute for an in-person, face-to-face, hands-on encounter when medically necessary.

See manual for acceptable CPT codes.


**Behavioral Health Organizations**

Store-and-forward reimbursable only for covered services specified in the negotiated agreement between the behavioral health organization and health care provider.

*Source: RCW 71.24.335.*

**Geographic Limits**

No reference found.
## Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Store-and-Forward</th>
<th>Transmission Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td></td>
</tr>
</tbody>
</table>

### Policy

The Medicaid agency covers the delivery of home health services and prescription drug monitoring through telemedicine.


### Conditions

Services are provided for clients who have been diagnosed with an unstable condition, and who may be at risk for hospitalization or a more costly level of care.

Coverage is limited to one telemedicine interaction, per patient, per day, based on the ordering licensed practitioner’s care plan.


### Provider Limitations

Must be provided by a Registered Nurse or Licensed Practical Nurse.

The Medicaid agency does not require prior authorization for the delivery of home health services through telemedicine.


### Eligible Services:

- Assessment and monitoring of clinical data including, but not limited to, vital signs, pain levels and other biometric measures specified in the plan of care;
- Assessment of response to previous changes in the plan of care;
- Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care;
- Implementation of a management plan.


Home health monitoring not covered in Applied Behavior Analysis Program for clients Age 20 or younger.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Email / Phone / Fax</strong></td>
</tr>
<tr>
<td>No reimbursement for email.</td>
</tr>
<tr>
<td>No reimbursement for telephone.</td>
</tr>
<tr>
<td>No reimbursement for FAX.</td>
</tr>
<tr>
<td><strong>Consent</strong></td>
</tr>
<tr>
<td>Written consent must be obtained for store-and-forward.</td>
</tr>
<tr>
<td><strong>Out of State Providers</strong></td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
</tr>
<tr>
<td>Requires the use of modifier 95 or GT. The GT modifier may be discontinued at a later date.</td>
</tr>
<tr>
<td>A new point of service code 02 has been created.</td>
</tr>
<tr>
<td>Additional Documentation Requirements for Telemedicine:</td>
</tr>
<tr>
<td>• Verification that the service was provided via telemedicine</td>
</tr>
<tr>
<td>• The location of the client and a note of any medical personnel with the client</td>
</tr>
<tr>
<td>• The location of the provider</td>
</tr>
<tr>
<td>• The names and credentials (MD, ARNP, RN, PA, CNA, etc.) of all people involved in the telemedicine visit, and their role in the encounter at both the originating and distant sites</td>
</tr>
</tbody>
</table>
“Telemedicine” means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, “telemedicine” does not include the use of audio-only telephone, facsimile, or email.

Source: WA Rev. Code Sec. 48.43.735.

Private Payer Laws

Requirements

Insurers (including employee health plans and Medicaid Managed Care) must reimburse a provider for services delivered through telemedicine or store-and-forward if:

- The plan provides coverage when provided in-person;
- The health care service is medically necessary;
- The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal patient protection and affordable care act (ACA);
- The health care service is determined to be safely and effectively provided through telemedicine or store-and-forward technology according to generally accepted health care practices and standards, and the technology used to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information.

Source: RCW 48.43.735.

Eligible Originating Sites

- Hospital
- Rural health clinic
- Federally qualified health center
- Physician’s or other health care provider’s office
- Community mental health center
- Skilled nursing facility
- Renal dialysis center, except an independent renal dialysis center
- Home or any location determined appropriate by the individual receiving the service
- Originating sites may not distinguish between rural and urban originating sites

Source: RCW 48.43.735.

An originating site (other than a home) can charge a facility fee, but it is subject to a negotiated agreement between the originating site and the health plan.

Source: RCW 48.43.735.

If the services are provided via store-and-forward, there must be an associated office visit between the patient and referring health care provider.

Source: RCW 48.43.735.
### Private Payer Laws

<table>
<thead>
<tr>
<th>Parity</th>
<th>Service Parity</th>
</tr>
</thead>
</table>
|        | Services must be considered an essential health benefit under the ACA and be determined to be safely and effectively provided through telemedicine or store-and-forward.  
*Source: RCW 48.43.735.* |

<table>
<thead>
<tr>
<th>Payment Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No explicit payment parity.</td>
</tr>
</tbody>
</table>

### Professional Regulation/Health & Safety

<table>
<thead>
<tr>
<th>Definitions</th>
</tr>
</thead>
</table>
| Telemedicine means the delivery of health care (or behavioral health) services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, ‘telemedicine’ does not include the use of audio-only telephone, facsimile, or email.”  
*Source: RCW 70.41.020 & WAC 246-335-610.* |

Telemedicine is when a health care practitioner uses HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located. Using telemedicine enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telemedicine allows clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.  
*Source: WAC 182-531-1730.*

**Hospice**

“Telehealth” means a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technology. Telehealth encompasses a broad variety of technologies and tactics to deliver virtual medical, health, and education services.  
*Source: WAC 246-335-610.*

**Physical and Occupational Therapy**

“Telehealth means providing physical therapy [or occupational therapy] via electronic communication where the physical [occupational] therapist or physical [or occupational] therapist assistant and the patient are not at the same physical location.”  
Consent

The WA Medical Quality Assurance Commission has issued guidelines on the use of the Internet in medical practices. A guideline does not have the force of law, but can be considered by the Commission to be the standard of practice in the state.

A documented patient evaluation, including history and physical evaluation adequate 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 in-person settings.

Treatment, including issuing a prescription, based solely on an online questionnaire or consultation does not constitute an acceptable standard of care.


Online Prescribing

Cross-State Licensing

Member of the Interstate Medical Licensure Compact.

Source: RCW 18.71B.

Member of Physical Therapy Compact.

Source: HB 1278 (2017).

Miscellaneous

WA State requires a provider directory to be updated monthly. For each health plan, the associated provider directory must include information about available telemedicine services and specifically described for each provider.

Source: WAC 284-43-204.

Professional Board Telehealth-Specific Regulations

- Physical Therapy Practice Board (Source: WAC 246-915-187)
- Occupational Therapy Practice Board (Source: WAC 246-847-176)

Collaborative for the advancement of telemedicine was created to develop recommendations on improving reimbursement and access to care, and review the concept of telemedicine payment parity.

Source: SB 6163 -2018.
West Virginia

Medicaid Program: West Virginia Medicaid

Program Administrator: Bureau for Medical Services, under the West Virginia Dept. of Health and Human Resources

Regional Telehealth Resource Center: Mid-Atlantic Telehealth Resource Center

Covers the States of: Delaware, Kentucky, Maryland, New Jersey, North Carolina, Pennsylvania, Virginia, West Virginia, and Washington D.C.

https://www.matrc.org

Medicaid Telehealth Reimbursement Summary

West Virginia Medicaid reimburses for live video under some circumstances. Reimbursement is only made for real time communications, therefore there is no reimbursement for store-and-forward or remote patient monitoring.

Medicaid Telehealth Reimbursement Definitions

“Telehealth: The use of electronic information and telecommunications technologies to provide professional health care; is often used to connect practitioners and clinical experts in large hospitals or academic medical centers with patients in smaller hospitals or critical access hospitals which are typically located in more remote locations; and can assure that these remotely located patients enjoy the same access to potentially life-saving technologies and expertise that are available to patients in more populated parts of the country.”

“The telecommunication system is defined as an interactive audio and video system that permits real time communication between the member at the originating site and the practitioner at the distant site. The telecommunication technology must allow the treating practitioner at the distant site to perform a medical examination of the member that substitutes for an in-person encounter.”


Telehealth – for purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>West Virginia Medicaid reimburses for a limited number of telehealth services that are provided to enrolled members by enrolled practitioners via a telecommunication system. WV Medicaid utilizes CMS guidance on Telehealth Services.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Eligible Services/Specialties</th>
<th>West Virginia Medicaid reimbursement of telehealth services is limited to certain CPT/HCPCS codes. See manual.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Targeted Case Management</th>
<th>Targeted case management can be conducted through telemedicine with the exception of the required 90 day face-to-face encounter with the targeted case manager.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>WV Medicaid encourages providers to render services via telehealth in the Behavioral Health Clinic Services program.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source:</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorized distant site providers include:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Authorized distant site providers include:</th>
<th>RHCs and FQHCs are not authorized to serve as distant sites for telehealth consultations, which is the location of the practitioner, and may not bill or include the cost of a visit on the cost report.</th>
</tr>
</thead>
</table>
## Medicaid Telehealth Reimbursement

<table>
<thead>
<tr>
<th>Authorized originating sites:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Offices of physicians or practitioners;</td>
</tr>
<tr>
<td>• Private Psychological Practices;</td>
</tr>
<tr>
<td>• Hospitals;</td>
</tr>
<tr>
<td>• Critical Access Hospitals (CAH);</td>
</tr>
<tr>
<td>• Rural Health Clinics (RHCs);</td>
</tr>
<tr>
<td>• Federally Qualified Health Centers (FQHCs);</td>
</tr>
<tr>
<td>• Hospital-based or CAH-based Renal Dialysis Centers (including satellites);</td>
</tr>
<tr>
<td>• Skilled Nursing Facilities (SNF); and</td>
</tr>
<tr>
<td>• Community Mental Health Centers (CMHC).</td>
</tr>
</tbody>
</table>

Independent Renal Dialysis Facilities are not eligible originating sites.


| WV Medicaid does not limit telehealth services to members in non-metropolitan statistical professional shortage areas as defined by CMS telehealth guidance. |


| An originating site can bill for a facility fee. |


| No reimbursement. WV Medicaid only reimburses for real time communications. |


<p>| No reference found. |</p>
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Store-and-Forward</th>
<th>Geographic Limits</th>
<th>Transmission Fee</th>
<th>Policy</th>
<th>Conditions</th>
<th>Provider Limitations</th>
<th>Other Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote Patient Monitoring</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reimbursement. WV Medicaid only reimburses for real time communications.</td>
<td>No reference found.</td>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

Medicaid Telehealth Reimbursement

Email / Phone / Fax

No reimbursement for FAX.
No reimbursement for telephone.
No reimbursement for email.


Consent

Patient consent must be obtained.


Out of State Providers

No reference found.

Miscellaneous

Additional instructions regarding telehealth standards and billing available in the following manuals: Licensed Behavioral Health Center Services (Ch. 503); Behavioral Health Outpatient Services (Ch. 521); School-Based Health Services (Ch. 538). Limited to specific CPT codes.


Private Payer Law

Definitions

No reference found.

Requirements

No reference found.
<table>
<thead>
<tr>
<th>Private Payer Law</th>
<th>Service Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

### Professional Regulation/Health & Safety

**Definitions**

"Practice of telemedicine means the practice of medicine using communication tools such as electronic communication, information technology or other means of interaction between a licensed health care professional in one location and a patient in another location, with or without an intervening health care provider, and typically involves secure real time audio/video conferencing or similar secure audio/video services, remote monitoring, interactive video and store-and-forward digital image or health data technology to provide or support health care delivery by replicating the interaction of a traditional in-person encounter between a provider and a patient. The practice of telemedicine occurs in this state when the patient receiving health care services through a telemedicine encounter is physically located in this state."

**Source:** WV Code Sec. 30-3-13.

"Telemedicine technologies” means technologies and devices which enable secure electronic communications and information exchange in the practice of telemedicine, and typically involve the application of secure real time audio/video conferencing or similar secure video services, remote monitoring, or store-and-forward digital image technology to provide or support healthcare delivery by replicating the interaction of a traditional in-person encounter between a physician or podiatrist and a patient.

**Source:** WV Code Sec. 30-3-13 & 30-14-12d (SB 47 – 2016).

**Medication Assisted Treatment Program**

“Telehealth” means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site.

**Source:** WV Code Sec. 16-5Y-2(z)(3)(cc) (SB 454—2016).

“Telehealth” means the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.

**Source:** WV Code, Ch. 16, Article 2D, Sec. 16-2D-2.

Telemedicine means the practice of medicine using tools such as electronic communication, information technology, store-and-forward telecommunication, or other means of interaction between a physician or podiatrist in one location and a patient in another location, with or without an intervening health care provider.

**Source:** WV Code, 30-3-13a.
Professional Regulation/Health & Safety

Consent

Must obtain consent.

Source: WV Code Sec. 30-14-12d (SB 47 – 2016).

Online Prescribing

A “valid patient-practitioner relationship” can be established through telemedicine in a manner approved by the appropriate board.

Source: WV Code Sec. 30-5-4.

A physician-patient relationship cannot be established through audio only communication, text communications or any combination thereof.

A physician-patient relationship can be established through real time video conferencing or store-and-forward (for pathology and radiology).

A physician or podiatrist may not prescribe any pain-relieving controlled substance listed in Schedules II through V of the Uniform Controlled Substance Act as part of a course of treatment for chronic nonmalignant pain solely based upon a telemedicine encounter.

Source: WV Code Sec. 30-3-13 & 30-14-12d (SB 47 – 2016).

Prohibits providers from issuing prescriptions, via electronic or other means, for persons without establishing an ongoing physician-patient relationship, wherein the physician has obtained information adequate to support the prescription.

Exceptions:

- Documented emergencies;
- On-call or cross-coverage situations;
- Where patient care is rendered in consultation with another physician who has an ongoing relationship with the patient, and who has agreed to supervise the patient’s treatment, including use of any prescribed medications.

Source: WV Code of State Rules Sec. 11-1A-12.

A practitioner providing medication-assisted treatment may perform certain aspects of telehealth if permitted under his or her scope of practice.


Cross-State Licensing

WV adopted the Federation of State Medical Board (FSMB)’s model language for an interstate medical licensure compact.


Member of the Physical Therapist Licensure Compact.

Source: PT Compact.

Member of the Nurse Licensure Compact.

Source: Nurse Licensure Compact.

Must hold active unexpired WV license.

Source: WV Code Sec. 30-3-13 & 30-14-12d (SB 47 – 2016).
Professional Board Regulation:

- Board of Examiners for Speech-Language Pathology and Audiology. \(\text{(Source: WV Admin. Law Sec. 29-1-15)}\).
### Medicaid Program

**Medicaid Program:** Forward Medicaid

**Program Administrator:** Wisconsin Dept. of Health Services

**Regional Telehealth Resource Center:** Great Plains Telehealth Resource and Assistance Center

**Covers the States of:** Iowa, Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin

[https://www.gptrac.org](https://www.gptrac.org)

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Forward Medicaid allows reimbursement for live video under some circumstances. There is no reimbursement for store-and-forward or remote patient monitoring as services must be delivered at the same functional equivalency as face-to-face care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Telehealth enables a provider who is located at a distant site to render the service remotely to a member located at an originating site using a combination of interactive video, audio, and externally acquired images through a networking environment.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Telehealth” is a service provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment between an individual at an originating site and a provider at a remote location with the service being of sufficient audio and visual fidelity and clarity as to be functionally equivalent to face-to-face contact. “Telehealth” does not include telephone conversations or Internet-based communications between providers or between providers and individuals.</td>
</tr>
</tbody>
</table>

**Source:** Wisconsin Statute 49.45 (29w)(b)1.b.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ForwardHealth allows for certain covered services to be provided via telehealth.</td>
</tr>
</tbody>
</table>

### Eligible Services / Specialties

Mental health services provided through telehealth are reimbursable by the Medical Assistance program if the provider of the service satisfies the following criteria:

- The provider is a certified provider of mental health services under the Medical Assistance program and is an agency that is certified by a mental health program organized under sections 46.23, 51.42 or 51.437.
- The provider and the individual providing the service comply with all Medical assistance coverage policies and standards.
- The provider is certified for telehealth by the department.
- The individual who is providing the service is licensed or registered and in good standing with the appropriate state board.
- The provider is located in the United States.
- The provider is not required to be located in the state.

**Source:** Wisconsin Statute 49.45 (29w)(b) (2).

### Eligible Providers

**Allowable providers:**
- Audiologists
- Nurse midwives
- Nurse practitioners
- Ph.D. psychologists
- Physician assistants
- Physicians
- Psychiatrists
- Professionals providing services in mental health or substance abuse programs certified by the DQA (Division of Quality Assurance)

**Ancillary Providers**

Claims provided via telehealth by distant site ancillary providers should be billed under the supervising physician’s NPI using the lowest appropriate level office or outpatient visit procedure code. These services must be supervised by an onsite physician.

**Certified Mental Health And Substance Abuse Treatment Providers**

Required to meet telehealth certification requirements to provide telehealth.

**Community Health Centers, Tribal FQHCs and RHCs**

They may serve as a distant site provider for telehealth services. See manual for details.

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Eligible Sites</th>
<th>Live Video</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Health Centers, Tribal FQHCs and RHCs</strong></td>
<td>They may serve as originating site providers for telehealth services.</td>
<td></td>
</tr>
<tr>
<td><strong>Distant Site</strong></td>
<td>Tribal FQHCs and RHCs may report services provided via telehealth on the cost settlement report when the FQHC or RHC served as the distant site and the member is an established patient of the tribal FQHC or RHC at the time of the telehealth service.</td>
<td></td>
</tr>
<tr>
<td>CHCs may not report services provided via telehealth as an encounter. Instead, CHCs should submit claims for distant site services on a professional claim form and will be reimbursed in accordance with the maximum allowable fee schedule.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allowable originating sites:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospitals, including emergency departments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office/clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Skilled nursing facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Geographic Limits</strong></td>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td><strong>Facility/Transmission Fee</strong></td>
<td>Reimbursement for facility fee.</td>
<td></td>
</tr>
<tr>
<td><strong>Store-and-Forward</strong></td>
<td>No reimbursement. Services must be functionally equivalent to face-to-face.</td>
<td></td>
</tr>
<tr>
<td><strong>Policy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eligible Services/Specialties</strong></td>
<td>No reference found.</td>
<td></td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
<td>Store-and-Forward</td>
<td>Geographic Limits</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

Remote Patient Monitoring  

<table>
<thead>
<tr>
<th></th>
<th>Transmission Fee</th>
<th>Policy</th>
</tr>
</thead>
</table>
|                 | No reference found.| No reimbursement. Services must be functionally equivalent to face-to-face. 


Remote Patient Monitoring  

<table>
<thead>
<tr>
<th>Provider Limitations</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
</tbody>
</table>

Remote Patient Monitoring  

<table>
<thead>
<tr>
<th>Other Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
<tr>
<td>Medicaid Telehealth Reimbursement</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td>Consent</td>
</tr>
<tr>
<td>Out of State Providers</td>
</tr>
<tr>
<td>Miscellaneous</td>
</tr>
<tr>
<td>Private Payer Laws</td>
</tr>
<tr>
<td>Definitions</td>
</tr>
<tr>
<td>Requirements</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Private Payer Laws</td>
</tr>
<tr>
<td>--------------------</td>
</tr>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reference found.</td>
</tr>
</tbody>
</table>

### Professional Regulation/Health & Safety

#### Definitions

Telemedicine means the practice of medicine when patient care, treatment or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine does not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, mail or parcel service or any combination thereof.

*Source: Admin. Code MED Ch. 24.*

#### Consent

Informed consent required.

*Source: Admin. Code MED Ch. 24.*

#### Online Prescribing

When a physician uses a website to communicate with a patient located in this state, the physician may not provide treatment recommendations, including issuing a prescription unless the following requirements are met:

- The physician shall be licensed in the state;
- The physician’s name and contact information must be made available to the patient;
- Informed consent is required;
- A documented patient evaluation performed;
- A patient health care record is prepared and maintained.

Prescribing based on a static electronic questionnaire does not meet the minimum standard of competent medical practice.

*Source: Admin. Code MED Ch. 24.*
Professional Regulation/Health & Safety

Cross-State Licensing

WI medical license required.

**Source:** Admin. Code MED Ch. 24.

WI adopted the Federation of State Medical Boards’ Interstate Medical Licensure Compact.

**Source:** Wisconsin Statute 14.89. WI Act 116 (AB 253, 2015).

Member of the Nurse Licensure Compact

**Source:** Nurse Licensure Compact

Miscellaneous

Professional Board Telehealth-Specific Regulations

- Medical Examining Board (**Source:** MED Ch. 24.)
**Medicaid Program:** Wyoming Medicaid  
**Program Administrator:** Office of Equality Care, under the Wyoming Dept. of Health  
**Regional Telehealth Resource Center:** Northwest Regional Telehealth Resource Center  
**Covers the States of:** Alaska, Idaho, Montana, Oregon, Utah, Washington, and Wyoming  
[https://www.nrtrc.org](https://www.nrtrc.org)

<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wyoming Medicaid reimburses for live video under some circumstances. There is no reference to store-and-forward or remote patient monitoring reimbursement.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>“Telehealth is the use of an electronic media to link beneficiaries with health professionals in different locations…This means that the patient must be able to see and interact with the off-site physician at the time services are provided via telehealth technology.”</td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement is made for exams performed via a real time interactive audio and video telecommunications system. The patient must be able to see and interact with the off-site practitioner during the exam. A medical professional is not required to be present with the client at the originating site unless medically indicated.</td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Live Video</th>
</tr>
</thead>
<tbody>
<tr>
<td>See manual for list of eligible hub site billing codes. Group psychotherapy is not a covered service.</td>
<td></td>
</tr>
</tbody>
</table>

For end-stage renal disease-related services, there must be at least one in-person exam per month of the vascular access site.  

Quality assurance/improvement activities relative to telehealth delivered services need to be identified, documented and monitored. An evaluation process must also be instituted.  

Progress notes should indicate the visit took place via teleconference.  

Wyoming Medicaid reimburses the following eligible providers:

- Physicians;
- Advanced practice nurses with a specialty of psychiatry/mental health;
- Physician’s assistant;
- Psychologists and neuropsychologists;
- Mental health professionals (LCSW, LPC, LMFT, LAT);
- Speech therapist.

Provisionally licensed mental health professionals cannot bill Medicaid directly, but must provide services through a supervising provider.


Eligible originating sites:

- Hospitals;
- Physician or practitioner offices (includes medical clinics);
- Psychologists or neuropsychologists offices;
- Community mental health or substance abuse treatment centers (CMHC/SATC);
- Advanced practice nurses with specialty of psychiatry/mental health offices;
- Office of a Licensed Mental Health Professional;
- Federally Qualified Health Centers;
- Rural Health Clinics;
- Skilled nursing facilities;
- Indian Health Services Clinics;
- Hospital-based or Critical Access Hospital-based renal dialysis centers (including satellites);
- Development Center;
- Family Planning Clinics;
- Public Health Offices;
- Client’s Home.

A medical professional is not required to be present at the originating site, unless medically indicated.

Each site is able to bill their own services as long as they are an enrolled Medicaid provider (includes out-of-state Medicaid providers).


No reference found.
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Facility/Transmission Fee</th>
</tr>
</thead>
</table>
| **Live Video**                   | Yes, for originating site fees.  
No reimbursement for transmission fees.  
  
| **Policy**                       | Wyoming Medicaid states that reimbursement is made for exams performed via a real-time interactive audio and video.  
  
<p>| <strong>Store-and-Forward</strong>            | No reference found. |
| <strong>Geographic Limits</strong>            | No reference found. |
| <strong>Eligible Services/Specialties</strong>| No reference found. |
| <strong>Remote Patient Monitoring</strong>    | No reference found. |</p>
<table>
<thead>
<tr>
<th>Medicaid Telehealth Reimbursement</th>
<th>Remote Patient Monitoring</th>
<th>Conditions</th>
<th>No reference found.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provider Limitations</td>
<td></td>
<td>No reference found.</td>
</tr>
<tr>
<td></td>
<td>Other Restrictions</td>
<td></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
| Email / Phone / Fax              |                           |            | No reimbursement for email.  
|                                 |                           |            | No reimbursement for telephone.  
|                                 |                           |            | No reimbursement for FAX.  |


| Consent                        |                           |            | If the patient and/or legal guardian indicates at any point that he/she wants to stop using the technology, the service should cease immediately and an alternative appointment set up.  
|                               |                           |            | A telehealth consent form must be completed.  |


| Out of State Providers         |                           |            | No reference found. |
### Miscellaneous

<table>
<thead>
<tr>
<th>Definition</th>
<th>Requirement</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reimbursement for patient attendants who instruct the patient on the use of equipment or supervises/monitors a patient during the telehealth encounter.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Definitions

- No reference found.

### Requirements

- No reference found.

### Parity

- **Service Parity**: No reference found.
- **Payment Parity**: No reference found.
### Definitions

**Physicians and Surgeons**

“Telemedicine means the practice of medicine by electronic communication or other means from a physician in a location to a patient in another location, with or without an intervening health care provider.”

*Source: WY Statutes Sec. 33-26-102.*

**Occupational Therapy**

“Occupational therapy telehealth means the provision of occupational therapy services across a distance, using telecommunications technology for the evaluation, intervention or consultation without requiring the occupational therapist and recipient to be physically located in the same place.”

*Source: WY Statutes Sec. 33-40-102.*

**Board of Chiropractic Examiners**

“Telehealth” means the delivery of healthcare services 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.

*Source: WY Admin Rules. Board of Chiropractic Examiners. Ch. 1, Sec. 3.*

### Consent

Written or oral consent required for physical therapy.

*Source: Code of WY Rules 006-062-00001.1.04162018 (2012).*

### Online Prescribing

Prescribing a controlled substance through the Internet, World Wide Web or any similar proprietary or common carrier electronic system without a documented physician-patient relationship is subject to review, discipline and consequences to license.

*Source: WY Statutes Annotated Sec. 33-26-402 (2012).*

### Cross-State Licensing

WY adopted the Federation of State Medical Board (FSMB)’s model language for an interstate medical licensure compact.

*Source: WY House Bill 107 (2015); WY Statute 33-26-701-703.*

**Member of the Nurse Licensure Compact**

*Source: Nurse Licensure Compact.*

### Miscellaneous

Boards have power to adopt telehealth/telemedicine definitions applicable to their regulated profession and standards for the practice of telemedicine/telehealth.

*Source: WY Code 33-1-303 (HB 164 – 2017).*

**Professional Board Telehealth-Specific Regulations**

- WY Board of Chiropractic Services *(Source: WY Admin. Code, Chiropractic Board, Ch. 11.)*
Glossary

Asynchronous (see also Store and Forward) technologies allow for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos. Asynchronous transmissions typically do not occur in real time, and take place primarily among medical professionals, to aid in diagnoses and medical consults, when live video or face-to-face patient contact is not necessary.

Broadband refers to the wide bandwidth characteristics of a transmission medium, and its ability to transport multiple signals and traffic types simultaneously. Broadband is often used to transmit telehealth and telemedicine services.

Centers for Medicare & Medicaid Services (CMS) is the federal agency that administers the Medicare, Medicaid and Children’s Health Insurance Program.

Children’s Waiver Services Program is a federal program that provides Medicaid-funded home and community-based services to children under age 18 who are eligible for, and at risk of, placement into an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

Consultant Site (see also Hub Site or Distant Site) is the site at which the provider delivering a telehealth service is located.

Critical Access Hospital (CAH) is a rural community hospital that receives cost-based reimbursement. The reimbursement that CAHs receive is intended to improve their financial performance and reduce hospital closures.

Current Procedural Terminology (CPT) Code is a medical billing and administrative code set that describes medical, surgical, and diagnostic services. It is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations and payers for administrative, financial and analytical purposes.

Distant Site (see also Hub Site or Consultant Site) is the site at which the provider delivering a telehealth service is located.

Durable Medical Equipment (DME) is any medical equipment, such as wheelchairs used in the home.

Echocardiography is a sonogram of the heart.

Echography is a radiologic procedure in which deep structures of the body are recorded with ultrasonic waves.

Electrocardiogram (ECG) is a test of the electrical activity of the heart, which helps detect medical problems such as heart attacks and arrhythmias.

E-Prescribing is the act of offering medical prescriptions over the Internet. Often, e-prescriptions must be accompanied by a valid physician-patient relationship, which may or may not require a face-to-face interaction between the physician and patient, depending on the state.

Facility Fee (see also Originating Site Fee) is a fee paid to the originating site to compensate for the cost of facilitating a telemedicine visit.

Federally Qualified Health Centers (FQHCs) are federally designated facilities, which provide primary care and other medical services to underserved populations.

Health Professional Shortage Area (HPSA) are designated by the Health Resources and Services Administration as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility).

Hub Site (see also Distant Site or Consultant Site) is the site at which the provider delivering a telehealth service is located.

Informed Consent refers to providers obtaining permission from a patient to perform a specific test, procedure, or in the case of telehealth, service delivery method. Informed consent means that the patient understands the relevant medical facts and risks involved.

Live Video Conferencing (see also Synchronous) refers to the use of two-way interactive audio-video technology to connect users, in real time.
Medicaid is a program that provides medical coverage for people with lower incomes, older people, people with disabilities, and some families and children. Learn more about the program in this section.

Medicaid Provider Manual is a document released by each state’s Medicaid agency, which serves as the reference document for its Medicaid program.

Medically Underserved Area (MUA) may be a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services.

Medicare is a health insurance for people age 65 or older, people under 65 with certain disabilities, and people of all ages with End-Stage Renal Disease. (ESRD is permanent kidney failure requiring dialysis or a kidney transplant.)

Modifier is a two-digit code that is added to medical procedure codes, to provide additional information about the billed procedure. In some cases, addition of a modifier can directly affect payment.

Modifier GQ is the modifier for store and forward technologies.

Modifier GT is the modifier for live video conferencing.

Originating Site (see also Spoke Site or Referring Site) is the location of the patient receiving a telehealth service.

Originating Site Fee (see also Facility Fee) is a fee paid to the originating site to compensate for the cost of facilitating a telemedicine visit.

Referring Site (see also Spoke Site or Originating Site) is the location of the patient receiving a telehealth service.

Remote Patient Monitoring uses telehealth technologies to collect medical data, such as vital signs and blood pressure, from patients in one location and electronically transmit that information to health care providers in a different location. The health professionals monitor these patients remotely and, when necessary, implement medical services on their behalf.

Rural Health Clinic is a clinic in a rural, medically underserved area that has a separate reimbursement structure from the standard medical office under the Medicare and Medicaid programs.

Skilled Nursing Facility (SNF) is a facility that houses chronically ill, usually elderly patients, and provides long-term nursing care, rehabilitation, and other services.

Spoke Site (see also Originating Site or Referring Site) is the location of the patient receiving a telehealth service.

Store and Forward (see also Asynchronous) technologies allow for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos. Asynchronous transmissions typically do not occur in real time, and take place primarily among medical professionals, to aid in diagnoses and medical consults, when live video or face-to-face patient contact is not necessary.

Synchronous (see also Live Video Conferencing) refers to the use of two-way interactive audio-video technology to connect users, in real time, for any type of medical service.

Tele-pharmacy involves a pharmacist in one location directing the dispensing of a prescription to another employee in a separate location.

Tele-presenter is a health professional who sits in the exam room with patients during telemedicine visits and assists the distant-site provider.

The Health Insurance Portability and Accountability Act (HIPAA) is a set of national standards, which includes security and privacy of health data for electronic health care transactions, and national identifiers for providers, health insurance plans and employers.

The program of All-Inclusive Care for the Elderly (PACE) provides comprehensive long-term services and support to Medicaid and Medicare beneficiaries.

Transmission Fee is a fee paid to telemedicine providers for the cost of telecommunications transmission.