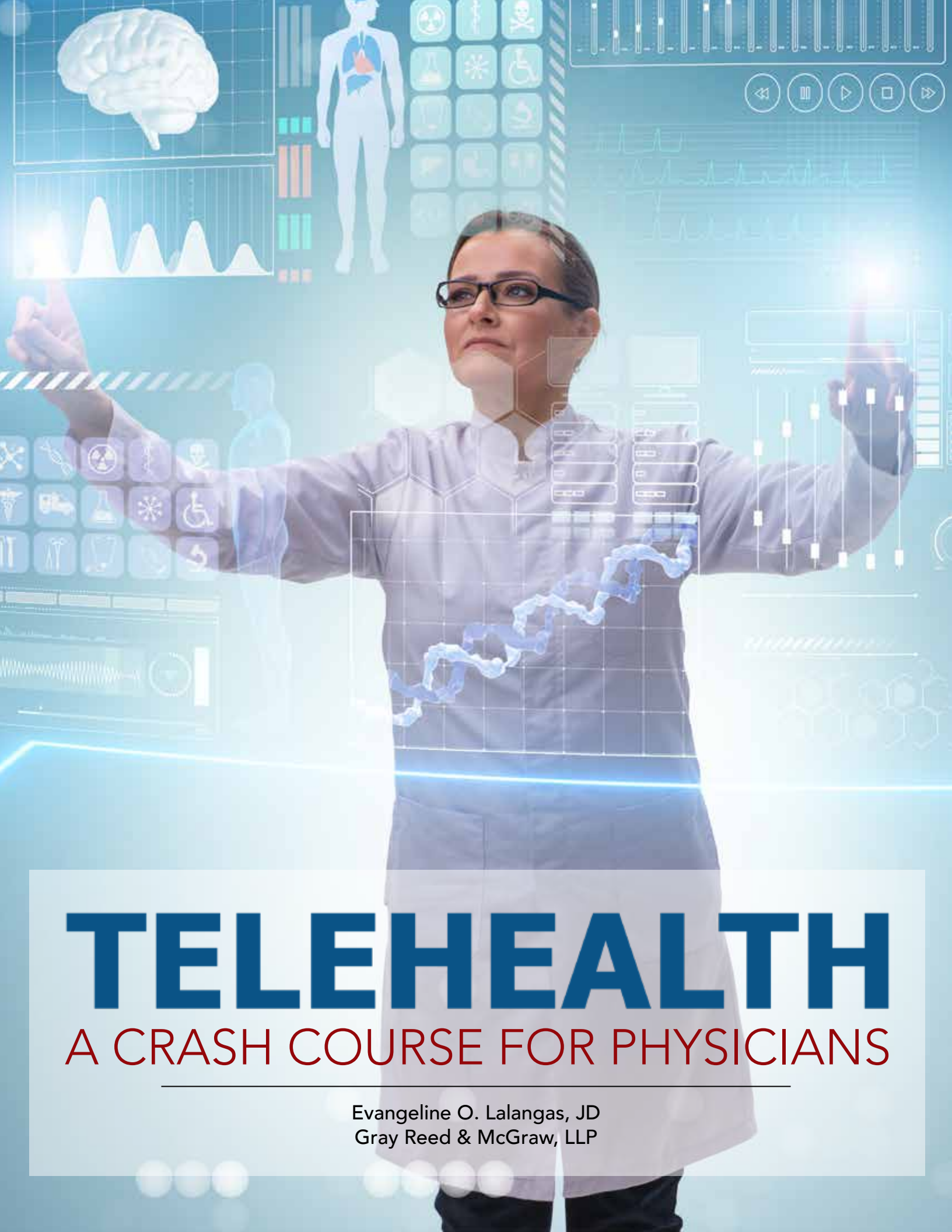

# TELEHEALTH

## A CRASH COURSE FOR PHYSICIANS

Evangeline O. Lalangas, JD
Gray Reed & McGraw, LLP

Twenty years in the making, "telehealth" has finally become a mainstream term. But confusion abounds as to what it is, what it does, how to use it, and how to provide it. Providers and patients alike have been slow to embrace it as a medium to provide and receive health care; in 2016, less than one percent of Medicare's fee-for-service reimbursements were for telehealth, even though Congress passed the first telehealth legislation in 1998.[1]

This article provides an overview of telehealth and the rules that physicians, specifically, must understand to provide telehealth-based services to their patients. Unfortunately, as in many areas of health care, switching to a telehealth-based practice or even adding telehealth services is not necessarily easy, quick, or inexpensive. Providers must first consider a multitude of variables to determine if and how they can offer telehealth including, for example, their practice area (specialty versus primary care), geographic location (rural versus urban), patient mix (uninsured, commercial payor enrollees, Medicare, etc.), just to name a few.

**What is Telehealth?**

On a global level, "telehealth" refers to the realm of providing care or health education to a patient in a different location than the provider. Often conflated with that term is "telemedicine." Telemedicine refers to the clinical aspect of providing care via technology, while telehealth, the more commonly used term, has a more global meaning encompassing the clinical side, but also remote-patient monitoring ("one-way" services), education services, and overarching communication platforms.

**How does it work?**

Telehealth offers two ways practitioners can interact with patients—"real time" synchronous, and "store and forward" asynchronous. "Real time" synchronous interactions are video visits between the practitioner and patient, whereas asynchronous ones are online exchanges of medical information between the practitioner and patients, e.g., via e-mail or other electronic messaging mediums, which may include videos, photographs, or merely written communications.[2]

**What Providers Need to First Ask Themselves**

For providers wanting to offer telehealth, the two most important questions to answer are:
(1) What kind of services will you provide? (Will they be clinical? Therapy-based? Educational?) and;
(2) In what setting will they be provided? Meaning, where will your patients be when they participate in a "real time" interaction, or online "asynchronous" exchange—their home, hospital, skilled nursing facility, and so on?

These questions are important because the answers dictate whether a provider can provide those services via telehealth, and what type of payors will reimburse them. A combination of federal and Texas laws, as well as payor reimbursement policies, answer these questions.

**Providing Telehealth to Medicare Beneficiaries**

It is important to first outline the Centers for Medicare and Medicaid's (CMS) policies on telehealth because, like with so many other new healthcare rules and regulations, CMS establishes the industry standard other payors look to emulate and build from. Medicare has very strict telehealth parameters providers must meet to receive reimbursement. They require that: (1) the patient be located in a qualifying rural area; (2) the patient be located at one of eight qualifying originating sites; (3) the patient receives services from one of ten eligible distant site practitioners; (4) the patient communicates with the distant site practitioner via an interactive audio and video telecommunications system with real-time communication; and (5) the CPT code for the service is included on CMS' list of covered Medicare telehealth services.[3]

As these rules stand, providers are incredibly limited on reimbursement opportunities for providing telehealth to Medicare patients; most importantly since the patient has to be in a rural area, and cannot be at home. Acknowledging these tight restraints, CMS established new "carve outs" in 2018 by reimbursing for certain services and exempting them from the above requirements. These include virtual check-ins, remote evaluation, and interprofessional internet consultation.[4]

Virtual check-ins are brief services via communication technology including a phone call allowing the provider to determine whether the patient needs an office visit or other service.[5] A physician or other qualified professional can facilitate the virtual check-in. Notably, only an "established patient" qualifies, meaning a patient who has been treated by the practice in the last three years.[6] Remote evaluation refers to a physician remotely evaluating a patient's condition using pre-recorded videos or images sent by the patient, requiring the provider to follow up within 24 hours.[7] Again, Medicare will reimburse this for only an "established patient."[8] Interprofessional internet consultation refers to assessment consultations between two providers concerning a patient's treatment.[9] However, it only applies when there is no need for an in-person meeting with the patient.

**Telehealth in Texas**

Today, Texas has one of the highest telehealth utilization rates. The state's combination of diverse practitioners, expansive geography, and growing populations makes it ideal ground for an alternative delivery model like telehealth. Ironically, Texas was the last state to update its telehealth rules, finally allowing practitioners to establish a patient relationship via telehealth instead of only via an in-person interaction.[10] Texas law does distinguish "telehealth" from "telemedicine," but for purposes of this article the terms reference the same type of services. Texas telehealth rules are relevant for practitioners treating Medicaid beneficiaries, commercially enrolled patients, and cash-pay patients.

Texas law requires that a physician be licensed here to provide telehealth services to Texas patients.[11] Generally, the same requirements apply regardless of whether a service is provided via telemedicine or in-person. For example, a physician must still establish a physician-patient relationship and is subject to the same standard of care that would apply if the service had been

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rendered in-person.[12] Similarly, the rules concerning medical records or patient privacy do not change when providing telehealth services. In addition, the patient must consent to treatment, but specifically that they will be treated via telehealth. The consent must outline telehealth's appropriate use, limitations, and risks, as well as potential fees.

In terms of payment, Texas payors are prohibited from excluding a covered telehealth medical service from coverage solely because the service is not provided through an in-person consultation.[13] Notably, Texas joined 28 other states in 2018 by passing a parity law, meaning commercial payors must pay for telehealth services the same way they would for in-person medical services. This law came into effect September 1, 2019.[14]

The biggest challenge for managed care-enrolled providers is that each such payor has their own telehealth rules with varying requirements. This renders both initial and ongoing compliance potentially cumbersome, particularly for solo practitioners or smaller practices with little bandwidth for added administrative duties. Typically, private payors will publish their policies about telemedicine coverage on their websites and to-date the major commercial payors cover telehealth.

One last aspect worth mentioning is the cost to buy a license for the telehealth technology, which may be prohibitively expensive for many until payors expand reimbursement opportunities. Practitioners with technology platforms should ensure they comply with federal and Texas privacy laws, and properly train all relevant staff on the appropriate use of such technology.

## Conclusion

Telehealth is ripe with opportunities for providers to offer more convenient, accessible, and often life-saving services to patients, particularly those with disabilities, those who have difficulty traveling, or those who are located in remote areas. At this time, it would be difficult if not nearly impossible for providers to establish a telehealth-only practice, particularly those with Medicare patients, but as utilization expands, so does administrative ease of access and understanding how to successfully incorporate telehealth into all types of providers' practices. **DMJ**

**Evangeline (Evie) Lalangas, JD**, brings an insider's perspective to the firm's health care and business services expertise. Evie's clients include hospitals, surgery centers, physicians, dentists, home health and hospice agencies, pharmacies, medical device companies, laboratories and other ancillary service providers. Institutional clients rely on Evie for compliance matters, fraud and abuse issues and negotiating and documenting transactions. She counsels clients on fraud and abuse laws, including the Anti-Kickback Statute, Stark Law, HIPAA, The Sunshine Act and other state and federal laws. Evie earned her B.A. in International Affairs from George Washington University and her JD and MPH. - Health Policy from St. Louis University.

## References

[1]Cntrs for Medicare & Medicaid Srvcs, Information on Medicare Telehealth, Nov. 15, 2018, Pg 2, available at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf.
[2]Social Security Act § 1834(m).
[3]Id. at (4).
[4]83 Fed. Reg. 59452.
[5]Id.
[6]Id. 59485. This patient could have been treated by any physician or professional within the same practice.
[7]Id. 59488.
[8]83 Fed. Reg. at 59452, 59488, and 59489.
[9]Id. 59489.
[10]See Information on Medicare Telehealth – Report to Congress, Centers for Medicare & Medicaid Services, dated November 15, 2018, at 2.
[11]See Tex. Occ. Code § 111.151.056. While Texas is among a number of states that offer a limited license to out-of-state physicians who want to practice telemedicine within their borders, this license is quite limited in scope as it only allows interpretation of diagnostic tests or follow up of patients where the majority of patient care was rendered in another state. See 22 Tex. Admin. Code §§ 172.12; 174.8.
[12]Tex. Occ. Code § 111.007.
[13]Tex Ins. Code § 1455.004.
[14]Texas Senate Bill 670.