TELEHEALTH: CONSENT, LICENSURE, LAWS AND LIABILITY

CONSENT:

- WV requires **verbal consent** prior to telehealth visits and this consent must be documented in the record.
- Generally, consent must consist of 4 components:
    1. Acknowledgement that telehealth cannot provide the same evaluation as an in-person visit
    2. Make patient aware that details of visit/medical issues may require that patient come into the office or ER/urgent care to be evaluated in person
    3. Inform patient the visit is encrypted and secure, but nothing is 100%
    4. Be sure patient understands their consent can be revoked at any time.

Example of simple documentation of verbal consent:

VERBAL CONSENT

Date: _____ Patient Name: _____ DOB: _____
Patient has requested and verbally consented to participation in telehealth visit. Patient acknowledges a telehealth visit cannot provide the same evaluation as an in-person visit. Medical issues discovered during the telehealth visit may require an in-person visit. This telehealth visit is conducted with encrypted and secure software. Note that copays and deductibles may apply depending on patient plan and presenting problem. Patient has the option to revoke consent at any time.

LICENSURE:
THIS IS PRIMARILY A **STATE CONTROLLED ISSUE**. THE STATE WHERE THE PATIENT IS PHYSICALLY LOCATED AT THE TIME OF THE VISIT GENERALLY DETERMINES THE LICENSURE LAW.

LICENSURE DURING COVID-19:
NATIONAL: MEDICARE AND MEDICAID:

- During the COVID-19 Emergency Waiver, there is temporary relaxation of requirement to be licensed in the state where patient is physically present (not where they reside). The provider must have a valid license in the state which relates to their Medicare enrollment, in furnishing services in the state where emergency is occurring and not excluded from practicing in that state or any other state that is part of the emergency. **State requirements still apply.**
- **Public Readiness and Emergency Preparedness Act (PReP Act)**: *(From Center for Connected Health Policy*)
  On Dec 3, 2020, HHS secretary amended the act a fourth time by creating a declaration to provide immunity from liability in certain circumstances. This declaration "allows healthcare personnel who are permitted to order and administer a ***Covered Countermeasure through telehealth*** in a state to do so for patients in another state so long as the healthcare personnel complies with the legal requirements of the state in which they are licensed or permitted to practice. Any state laws that prohibit the qualified person from ordering and administering the covered countermeasures through telehealth is preempted, including licensing laws. It is important to note that this exception from licensure, and immunity protection is ***extremely limited***. It applies only to healthcare personnel ordering or administering the covered countermeasures described below. It does **NOT** apply to all types of healthcare providers or services. A Covered Countermeasure as in this act is defined as:
    - A qualified pandemic or epidemic product

- A security countermeasure
- A drug, biological product, or device that is authorized for emergency use, or
- A respiratory protective device that is approved by the National institute for occupational safety and health

LICENSURE POST COVID-19:

- MEDICARE AND MEDICAID: Must have a license in the state where patient is physically present.
- COMMERCIAL INSURANCES:
  - Interstate Medical Licensure Compact (IMLC): WV does participate as a State of Principal Licensure (SPL) in the IMLC thus allowing members expedited pathway for licensure in WV and for those from WV to be licensed similarly in multiple other participating states. This is separate licensing process from the usual medical license in WVBOM. NOTE: All states surrounding WV do not fully participate yet.

WV LAWS AFFECTING TELEHELATH LICENSURE DURING AND POST COVID:

Governor Emergency Authorization: March 16, 2020:

- **WV BOM (M.D., PAs)**: Due to the State of Emergency declared by the Governor, physicians and/or physician assistants licensed in another state or **who are inactive or retired from West Virginia practice may provide medical care in West Virginia under special provisions during the period of the declared emergency**, subject to such limitations and conditions as the Governor may prescribe. Registrants may practice medicine in West Virginia consistent with their scope of practice and the standard of care and may practice in person or via telemedicine technologies to West Virginia patients. To register, out of state physicians and physician assistants:
  (1) must hold a valid, permanent, current, and unrestricted license to practice in another state.
  (2) must not be the subject of a pending or active complaint, investigation, Consent Order, Board Order or pending disciplinary proceeding in any jurisdiction; and
  (3) must not have not surrendered a license while under investigation or had a license revoked in any jurisdiction.
- **WV Board of Osteopathy (D.O.s)**: To maximize the number of healthcare providers available during the State of Emergency declared by Governor Jim Justice regarding the COVID-19 pandemic, the Board has developed procedures for **emergency temporary permits** for the following practitioners:
  (1) Out-of-State Practitioners: DOs and PAs who have no pending complaints, investigations, consent orders, board orders, or pending disciplinary proceedings and who possess valid, unrestricted medical licensure in another state, district, or territory of the United States…
  (2) Individuals seeking an emergency temporary permit may not begin practicing in West Virginia until they have received authorization from the Board.
  (3) Individuals obtaining an emergency temporary permit shall be subject to the Board's jurisdiction…
  (4) Emergency Temporary Permits will remain valid until terminated by the Board or the State of Emergency is lifted, whichever occurs first.
  (5) Re: renewals - The extended deadline for licensure renewals, brought about by the COVID-19 pandemic, expired September 30, 2020. Under normal circumstances, the renewal period, which began online May 11, 2020 would have concluded on June 30, 2020… •
  (6) Status – Active until the end of the COVID-19 emergency

HB2024 ***PASSED*** Emergency Rule for Interstate Telehealth Services: (Effective from passage March 30, 2021) WV 30-1-26 (Permanent)

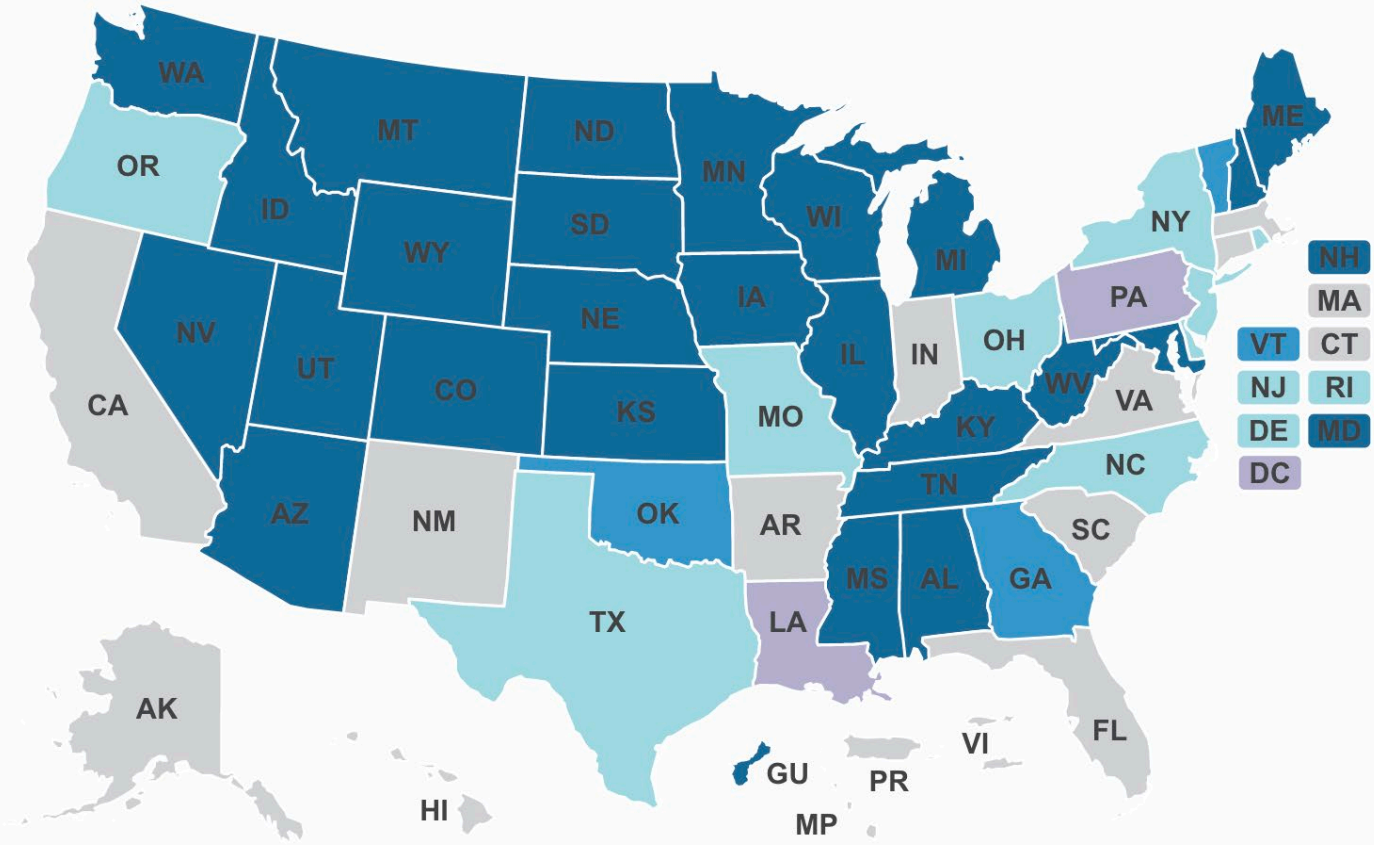
- Established ability of providers outside the state of WV to care for patients in WV during emergencies through special registration
- Providers must be in good standing and without current investigation in their home state.
- Must provide care in their scope of practice.
- Must register with the appropriate licensing board in WV and pay a fee. Board may impose discipline.
- May provide care by synchronous or asynchronous Audio only or Audio Visual, Remote Patient Monitoring. Does not include email, fax or questionnaires.
- There must be an IN PERSON visit to a provider within 12 months prior to telehealth encounter. Exceptions: Case by case rule by practitioner, such as:
  - post op follow-up
  - acute in-patient telehealth consultations
  - behavioral health telehealth
  - addition medicine telehealth
  - palliative care
- Can't perform these visits from within a location in WV without a WV license.
- **Can't prescribe Schedule II medications** unless allowed by another section. This does not apply to a physician or a member of the same group practice of the established patient.

Another way for physicians to practice in multiple states:
From the **Interstate Licensure Compact**:

The Interstate Medical Licensure Compact is an agreement among participating U.S. states to work together to significantly streamline the licensing process for physicians who want to practice in multiple states. It offers a voluntary, expedited pathway to licensure for physicians who qualify.

The mission of the Compact is to increase access to health care – particularly for patients in underserved or rural areas. The Compact makes it possible to extend the reach of physicians, improve access to medical specialists, and leverage the use of new medical technologies, such as telemedicine. While making it easier for physicians to obtain licenses to practice in multiple states, the Compact also strengthens public protection by enhancing the ability of states to share investigative and disciplinary information.

U.S. State Participation in the Compact



= Compact Legislation Introduced
= IMLC Member State serving as SPL processing applications and issuing licenses*
= IMLC Member State non-SPL issuing licenses*
= IMLC Passed; Implementation In Process or Delayed*

* Questions regarding the current status and extent of these states' and boards' participation in the IMLC should be directed to the respective state boards.

SPL: State of Principal Licensure

TELEHEALTH LAW:

It is important to realize there are **FEDERAL LAWS and STATE LAWS** playing a role in telehealth. **Federal laws relate mostly to Medicare. State laws relate mostly to Medicaid and commercial insurers.**

Federal Medicare telehealth policy mostly originated in 1997 and updated in 2000. Not much had changed since, until COVID 19 Pandemic hit. Many of the changes in policy since the Public Health Emergency started have been temporary and will require legislation for permanent change. It is important to determine what is temporary and what it permanent.

TIMELINE OF FEDERAL LAWS AFFECTING TELEHEALTH:

- **WAIVER 1135**: Jan 31, 2020: HHS Secretary declared a **Public Health Emergency (PHE)** on Jan 31, 2020 and will remain in effect until the end of the emergency is declared. Renewed to July 20, 2021 as of the writing of this document.
- March 1, 2020: RHC and FQHCs **Audio-only telehealth services allowed**. SEE CMS website for codes billable with Audio-only vs those requiring Audio-visual component.
- March 6, 2020: HHS **expanded number of codes billable by telehealth**. HHS stated they would not perform audits to determine if telehealth patient was "established" or not.
- March 6, 2020: **RHCs and FQHCs can act as distant site** with provider at home or at clinic. Patient can be at home.
- **CARES ACT *PASSED***: **HR 6074: SIGNED March 17, 2020**: **Waived the previous requirements for originating and distant sites for telehealth.**
    a. Allowed telehealth for New patients during the PHE (not permanent)
    b. Removed policy on facility fees. Facility fees defined in COVID 19 policy
    c. Removed the requirement of Audio-visual and allowing just audio for visits with some codes
    d. FQHCs and RHCs can act as distant sites during the PHE (not permanent). Costs for telehealth visits will not be used to determine the payment amount for PPS/AIR
    e. Secretary of HHS now able waive monthly face-to-face requirement for dialysis patients, and for re certification of hospice patients, and home health services during the PHE (NOT PERMANENT)
- March 19, 2020: **CMS issues guidance on HIPAA and Telehealth**
    a. OCR will exercise enforcement discretion and will not impose penalties for noncompliance with HIPAA Rules in connection with the good faith provision of telehealth during the COVID -10 PHE.
    b. Provider can use audio or video communication technology to provide telehealth as long as non-public facing. For example, cannot use Facebook Live, Twitch, TikTok etc.
    c. Use of vendors that are HIPAA compliant and will enter into Business Associate Agreements (BAAs) are preferable.
- March 29, 2020: HR 748: **Expanded list of eligible providers** and Interim Rule from CMS
- March 30, 2020: CMS **expands list of eligible telehealth codes** by adding 80 more codes. Total of 280.
- April 7, 2020: First CMS **Guidance for FQHCs/RHCs** issued.
    a. Supervision can be virtual via Audio Visual.
    b. RHC and FQHC can be distant sites.
    c. COVID 19 specimen collection is not separately reimbursable in RHC and FQHCs.
    d. RHC and FQHC can bill G2025 for any telehealth code allowable by Medicare.
    e. To bill Audio only: Must be more than 5 min of time and NOT originating from a visit within the last 7 days or lead to an E and M service in the next 24 hours (or next available).
    f. Allowed for E Visits using code G0071
- May 27, 2020: **Updated CMS Guidance for FQHCs/RHCs** issued
    a. RHC to report originating and distant site cost on CMS 222-17 on Line 79 of Worksheet A as "Cost other than RHC services".
    b. FQHC to report originating and distant site cost on CMS 224-14 on Line 66 of Worksheet A as "Other FQHC services".

- April 8, 2021:
    a. CMS **expands eligible providers to all those eligible to bill Medicare** for their professional services, including OT, PT, Speech therapists. Can also bill "Incident to" telehealth for some other providers such as respiratory techs.
    b. **Allows audio only for certain services previously requiring Video component**, particularly, behavioral health, medical nutritional therapy, speech therapy, physical therapy, speech therapy codes.
- **THE TELEHEALTH MODERNIZATION ACT of 2020**: **PENDING**: Bipartisan legislation introduced in both House and Senate to make the expanded access to telehealth services permanent. This law would lift the rural-only restriction and add any site where a patient is located as a potential originating site. This would ensure all Medicare beneficiaries may receive covered Medicare telehealth benefit, including at home and via mobile technologies as appropriate.
- **CONSOLIDATED APPROPRIATIONS ACT OF 2021, *PASSED***: **SIGNED Dec 27, 2020.** This 5000+ page bill contained several sections relevant to telehealth.
    a. First: Addition of new payment designation of rural emergency hospital (REM) for facilities of 50 beds or less to the list of originating sites eligible for reimbursement (still needing to meet CMS telehealth definition of 'Rural" with HRSA qualifications and must be eligible provider and services).
    b. Second: **Exemption from Medicare's rural geographic requirement** for eligible telehealth individuals for purposes of diagnosis, evaluation, and management of a **mental health disorder** once the COVID 19 emergency ends. (The same exemption already exists for treatment of substance use disorder.) **One caveat: Provider must have had at least one in-person visit with patient within the prior 6 months. This requirement renews with EACH telehealth visit.**
    c. Third: **Maternal, Infant and Early Childhood Home Visit Program**, during COVID 19 emergency, a **virtual home visit** can be considered a home visit.
    d. **Significant funding** is dedicated to assessment and mitigation of the **broadband "digital divide"** to improve access to those in rural and remote areas.
- **CONNECT for HEALTH ACT of 2021: SB 1512 PENDING**. Designed to remove barriers to telehealth coverage, establish program integrity and evaluate data and testing of models. There are many areas of telehealth affected by this bill.
    - **DEFINITIONS**:
        - **"telecommunications system"**: Current law requires telehealth to occur via an interactive telecommunications system. CMS has interpreted that to be synchronous audio-video and needs congress to redefine this in order to permanently allow audio only telehealth visits. This bill proposes that the HHS Secretary be allowed to "modify the definition when appropriate". It is the intent of congress that audio only telehealth be allowed permanently.
    - **LOCATION OF PATIENT**:
        - Geographic Limitations will be removed.
        - Home will be allowed as originating site for all services
        - HHS Secretary may allow additional sites and develop rules and policy for those sites
        - Geographic limitations will not apply to Indian Health Service (HIS) Facility
        - Geographic limitations will not apply if providing emergency care
        - There will be no facility fees for some of these new locations such as home
    - **PROVIDERS:**
        - RHCs and FQHCs will be able to act as distant sites (permanently)
        - RHCs and FQHCs will receive their prospective payment service rate instead of the G2025 rate as in the PHE.
    - **SERVICES COVERED**:

        - HHS Secretary will have ability to temporarily add services to the list eligible for telehealth
    - **ADDITIONAL ITEMS**: HHS Secretary shall have the ability to waive
        - Originating site limitations
        - Geographic limitations
        - Limits on types of technology used
        - Eligible providers for CMS telehealth services
        - Types of CMS Services covered by telehealth
        - Any other limitation HHS Secretary deems necessary
- The Protecting Rural Telehealth Access Act,(***Introduced***). Manchin, Joe (D-WVa), Ernst, Joni (R-Iowa), Shaheen, Jeanne (D-NH).
    - Payment parity for audio-only health services for clinically appropriate appointments for patients wherever they are located.
    - Permanently waive the geographic restriction allowing patients to be treated from their homes.
    - Pemanently allow RHCs and FQHCs to serve as distant cites for provision of telehealth services.
    - Lift the restrictions on "store and forward" technologies for telehealth in all states.

What DID CMS do permanently so far?
As of Dec 2020, CMS added the following services permanently:

- G2211 – ON HOLD: Visit Complexity with certain office/outpatient evaluation and management services (now delayed for 3 years)
- G2212 or 99417 – ADDED: Prolonged office or other outpatient evaluation and management service(s). (full 15min)
- 90853 - Group Psychotherapy
- 96121 - Psychological and Neuropsychological Testing
- 99483 – Care Planning for Patients with Cognitive Impairment
- 99334 - Domiciliary, Rest Home, or Custodial Care services
- 99335 - Domiciliary, Rest Home, or Custodial Care services
- 99347 & 99348 – Home Visits

WV STATE TELEHEALTH LAW:

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  (1) must hold a valid, permanent, current, and unrestricted license to practice in another state;
  (2) must not be the subject of a pending or active complaint, investigation, Consent Order, Board Order or pending disciplinary proceeding in any jurisdiction; and
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Medicaid: Moved to **permanently** allow Clinical psychologists and Psychiatrists at FQHCs and RHCs to act as a DISTANT site.

WV HB4003: Effective March 25, 2020: **Private Payer Law**:

- If the service is paid for in person, it will be paid for via telehealth. Fee for service is negotiated by Private Payer and Provider.
- Originating site is where the patient is located no matter where that may be.
- Defined telehealth as synchronous or asynchronous and remote patient monitoring need not be uploaded electronically.
- There will be no annual or lifetime limits on telehealth benefits. Originating site may charge a site fee.
- Prohibits Schedule II prescriptions unless allowed in another section.

WV HB2024 (Effective from passage March 30, 2021)

- <u>Insurance Coverage</u>:
  - Plans must cover telehealth if same service covered for face-to-face visits.
  - Fees for services are negotiated for face-to-face and will be reimbursed equally if provided by telehealth.
  - Plans cannot exclude a service just on the basis of provision by telehealth
  - Annual or lifetime limitations of benefits for telehealth services are prohibited.
  - Provider/hospital allowed to charge "originating site" fee if appropriate.
- <u>Emergency Rule for Interstate Telehealth Services</u>:
  - Established ability of providers outside the state of WV to care for patients in WV during emergencies through special registration
  - Providers must be in good standing and without current investigation in their home state.
  - Must provide care in their scope of practice.
  - Must register with the appropriate licensing board in WV and pay a fee.
  - May provide care by synchronous or asynchronous Audio only or Audio Visual, Remote Patient Monitoring. Does not include email, fax or questionnaires.
  - There must be an IN PERSON visit to a provider within 12 months prior to telehealth encounter. Exceptions: Case by case rule by practitioner, such as: post op follow-up, acute in-patient telehealth consultations, behavioral health telehealth, addiction medicine telehealth and palliative care.
  - Can't perform these visits from within a location in WV without a WV license.

- Prescribing Limitations
    - No prescribing of Schedule II drugs.
    - Any provider who sees a patient solely through telemedicine, cannot prescribe Schedule II to that patient. Exceptions: Minor (under 18) and those 18 and older in primary or secondary education with intellectual or developmental disabilities, neurological disease, ADHD, autism, traumatic brain injury.
- Requirements for Documentation
    - VERIFY identity and location of PATIENT.
    - PROVIDE identity, qualifications, location and contact information of the provider.
    - Provider must DETERMINE is telehealth is appropriate type of service for the patient's problem.
    - OBTAIN and DOCUMENT consent.
    - Provide evaluation and management as if patient was being seen in person.
    - Health record CONTENT should reflect all of the above

TELEHEALTH LIABILITY:

TORT vs NON-TORT CLAIMS:
There can be claims re patient care. Once you have established a doctor patient relationship, even if that is done via telehealth, you may be liable. Also, there can be non-tort claims for privacy and security issues, licensure, credentialing, reimbursement and issues with data collection.

REMINDER:
Check with your insurer to make sure your services provided by telehealth are covered under your current malpractice policy.

PATIENT SELECTION:
Choose allowable problem types wisely. Those more serious problems or those requiring a physical exam for diagnosis such as eye problems, abdominal pain, new multisystem complaints and gynecologic problems are better suited for face-to-face visits.

SPECIAL CIRCUMSTANCES:
BE AWARE OF SPECIAL CIRCUMSTANCES: Prepare and practice dealing with:

1. Hearing and sight impaired patients
2. Patients requiring a chaperone
3. Those who wish to add a third party at a different location
4. Patients who speak a different language than provider or have limited proficiency (must have ability to provide interpreter). Contract with an online interpreter company for as needed use or use and interpreter in your office. May require special scheduling.