

# 50-State Survey of Telehealth Insurance Laws

Third Edition

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*Includes a Comparison  
of Laws Before and After  
the Public Health Emergency*



APRIL 2024

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Includes a Comparison of Laws Before and After the Public Health Emergency

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## ABOUT FOLEY & LARDNER'S TELEMEDICINE AND DIGITAL HEALTH INDUSTRY TEAM

Foley's Telemedicine and Digital Health Industry Team has been referred to as "*the premier firm for telehealth counsel*," "*a market leader in telemedicine issues*" and "*the Dream Team*." Using a team-based approach of deep subject matter experts, we help established and emerging companies build innovative virtual care programs, create scalable and sustainable digital health companies, and reach patients in new markets around the block and around the world. We are committed to helping clients fulfill their goals of harnessing new technology to meet patient needs anywhere, delivering care without borders or geographic limitations. Our lawyers help create fully fledged telemedicine offerings, delivering end-to-end legal services by coupling precise strategic guidance with "*a stunningly high level of care and responsiveness*" to maintain that sense of urgency necessary to launch new initiatives and remain competitive in the marketplace.

The depth and breadth of our experience, the qualifications of our attorneys, our unparalleled insight and knowledge of the telemedicine and digital health industry, and our work with some of the best and brightest names in health care allows us to deliver unique value. Our approach to working with clients is collaborative, deliberate, and actionable. One firm; all your digital health needs.

\*All quotes were provided by clients and lawyers from peer law firms and published by *Chambers USA: America's Leading Business Lawyers*.

## About This Report

Telemedicine and digital health technology continues to gain broad adoption among patients and health care professionals alike, with more organizations implementing and expanding robust virtual care services either as standalone programs or as a supplement to traditional in-person offerings. When Foley & Lardner's first nationwide telemedicine and digital health survey was published in 2014, our findings revealed that one of the most significant barriers to telehealth adoption was limited or uncertain coverage and reimbursement. A decade later, significant progress has been made – both legislative and technological – to advance the widespread use of virtual care services across the United States.

In 2020, the COVID-19 pandemic prompted state and federal policymakers to temporarily waive legal restrictions and materially expand coverage and reimbursement for virtual care services at a scale previously unseen. By temporarily eliminating restrictions and opening up coverage, the Public Health Emergency (PHE) offered telehealth providers the freedom to experiment and a chance to challenge previously-held presumptions about the efficacy and value of virtual care. After the PHE concluded in May 2023, studies began to emerge evaluating how these waivers affected patient care, access, quality, and medical spend. The findings indicated that waiving the telehealth laws during the PHE did not result in widespread quality of care failures nor increase fraud & abuse. Instead, the PHE years proved to the general public what a dedicated group of committed “tele-vangelists” believed for years: telehealth is a key tool to reach the coveted Triple Aim and can do so without being feared as a budget buster on medical spend. Accordingly, while the waivers were initially temporary and slated to end when the PHE expired, many states (and the Medicare program) made these waivers permanent, codifying them into law.

Foley & Lardner's 50-State Survey of Telehealth Insurance Laws provides a detailed report on each State's telehealth commercial insurance coverage and payment/reimbursement laws. This comprehensive survey contains pinpoint citations to the governing statutes and regulations on telehealth commercial health insurance laws, as well as the full text of those laws and regulations as a reference tool. The report

does not include Medicaid or Medicaid managed care laws, which also vary on a state-by-state basis, and can be found primarily in state Medicaid program handbooks and regulations. The report is useful to health care providers (both traditional and emerging), lawmakers, entrepreneurs, telemedicine companies, and other industry stakeholders as a guide of telehealth insurance laws and regulations across all 50 states and the District of Columbia. This is the Third Edition of Foley's report, with the First Edition published in 2019 and the Second Edition published in 2021.

This report is for informational and educational purposes only and is not intended as a comprehensive statement of the law on this topic. It is not legal advice and cannot be relied upon as legal advice. The tables contained herein are an interpretive summary only and apply the most general coverage provision and/or the predominant answer across the state. There may be variances across coverage laws, and laws and rules are constantly changing, so be certain to reference and read the statutes and regulations for precise legal requirements. If you have questions on telehealth law or billing, coding, and reimbursement rules, consult with your legal counsel, certified billing and coding professionals, and/or your local Medicare Administrative Contractor. Our research was last comprehensively conducted from February 2024 through April 2024, and the authorities could be amended at a later date. Please note some states have multiple telehealth coverage laws applicable to various policy, service, and/or provider types.

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Nathaniel (Nate) Lacktman is a partner and Chair of Foley & Lardner's national Telemedicine & Digital Health Industry Team. He serves on the Board of Directors of the American Telemedicine Association. Nate advises entrepreneurial health care providers and technology companies on business arrangements, compliance, and corporate matters, with particular attention to telehealth, digital health, and health innovation. Working with entrepreneurs, hospitals, providers, and start-ups to build telemedicine arrangements across the United States and internationally, his practice emphasizes strategic counseling, creative business modeling, and fresh approaches to realize clients' ambitious and innovative goals. He speaks and writes frequently on issues at the forefront of telehealth and is often quoted for his insight about legal and business developments in this area. He has written telehealth legislation, regulations, comment letters, and policy input to lawmakers, the Drug Enforcement Agency, the Congressional Research Service, state Medicaid Agencies, and state boards of medicine across numerous states. He is the 2019 recipient of the ATA's Champion Award, which recognizes an individual who has made significant contributions to advocate for public policy changes that open payment support and provide regulatory pathways for telemedicine and digital health.

\* The authors would like to extend their gratitude to Jane Blaney, Esq., for her for research contributions to this Third Edition.



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Jacqueline Acosta is a health care lawyer and member of the firm's national Telemedicine & Digital Health Industry Team. Jacqueline focuses her practice on regulatory and compliance issues for health industry clients, including leading telehealth and digital health companies, physician practice groups, start-up telehealth and digital health companies and hospitals and health systems. Jacqueline's focus is on assisting telehealth companies and providers navigate multi-state telehealth practice standards, such as allowable modalities, patient consents, remote prescribing and provider licensure issues. Her experience also includes telehealth commercial health insurance coverage and reimbursement issues, compliance with the federal Ryan Haight Act, Medicare and Medicaid enrollment and coverage issues and fraud and abuse compliance. Jacqueline regularly assists clients with an end-to-end review of their technology platforms for compliance with consumer privacy laws, telehealth consent requirements, medical intake forms, allowable modalities, pharmacy integration and payment issues.



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# Noteworthy Legal Changes: Before and After the Public Health Emergency

In the time since our 2019 report, the legal landscape for telehealth insurance coverage and reimbursement has significantly expanded. Comparing the laws before and after the PHE, our research identified the following notable changes:

## 1. More Prohibitions Against Exclusive Telehealth Platform Arrangements

After the PHE ended, a number of states changed their laws to prohibit health plans from mandating in-network providers use a specific telehealth software platform or app in order for the member to receive insurance coverage. Similar laws were enacted to prohibit exclusive contracting arrangements between health plans and telehealth platforms, vendors, or service providers (including those affiliated with or controlled by the health plan). These restrictions existed in some states before the PHE, but were notably expanded to more states as of 2024.

The changes should offer more opportunity for individual clinics and hospitals to use whatever software platform they prefer, which is good for competition and opportunities among software companies. By limiting exclusive contracting arrangements, the changes should help ensure patients can obtain covered telehealth services from their in-person doctor, rather than requiring the patient to obtain in-person services from one doctor and telehealth services from a different medical group. Whether or not the changes result in increased competition (and therefore increased quality and decreased costs), time will tell.

## 2. Permanent Audio-Only Coverage Enters the Scene

Before the PHE, health plans did not separately reimburse for telephone calls with patients. Although the American Medical Association had for years advocated to reimburse telephone calls (and even created telephone call CPT codes decades ago), Medicare and health plans considered such services to be covered but not separately payable under the notion that phone calls were part of the pre- or post-work of an otherwise covered service (typically an E/M visit). Phone calls were something clinicians did for patients, but could not receive additional reimbursement for that work. All that changed during the PHE when Medicare and most health plans temporarily offered separate reimbursement for audio-only services. The payment was immediately popular with clinicians and patients because it allowed people to obtain virtual care services even in areas with low speed internet access while simultaneously compensating clinicians for that medical visit.

Audio-only telehealth was so popular during the PHE that approximately 18 states passed laws to make such coverage permanent for health plans. These states now require coverage and/or separate reimbursement for audio-only services, predominantly for mental health (e.g., Georgia, Hawaii, Nebraska, Nevada) or where other telehealth modalities are not feasible due to lack of adequate broadband access or are otherwise impractical or not medically advisable (e.g., Georgia, Kentucky, Tennessee). That is a significant and material change from 2019.

Even with this newly-expanded coverage, reimbursement rates for audio-only services vary. Hawaii mandates coverage for audio-only mental health services, and sets the reimbursement rate at 80% of the rate for equivalent in-person services. Separate from payment, some states prohibit a clinician from establishing a new clinician-patient relationship via audio-only, and the initial exam must be via audio-video or in-person and audio-only cannot be used with new patient relationships.

2019

2024


**18** states passed audio-only telehealth laws to make such coverage permanent for health plans



### 3. Mental and Behavioral Health Enjoys Expanded Telehealth Coverage and Payment Parity

It is no secret the United States is experiencing a supply-demand imbalance between the number of patients seeking medical care and the limited number of clinicians available to provide such care. This imbalance is particularly felt in the mental and behavioral health field. States have taken notice and action to help address this imbalance by guaranteeing expanded insurance coverage and payment of telehealth-based mental and behavioral health services.

Following the PHE, approximately 11 states passed laws requiring coverage and payment parity for mental and behavioral health services delivered via telehealth. Much of this expansion came by recognizing audio-only modalities, but the expansion happened in other ways as well. For example, Iowa law now holds that a health plan cannot exclude out-of-state mental health providers from participating in the health plan so long as the mental health provider is licensed in Iowa and able to satisfy the same criteria as required for mental health providers physically located in the state. Iowa also added a payment parity provision, but only for mental health services.

**2x**  **increase in states** that now have laws on payment parity or reimbursement rates in **2024**, compared to **16 states** in **2019**

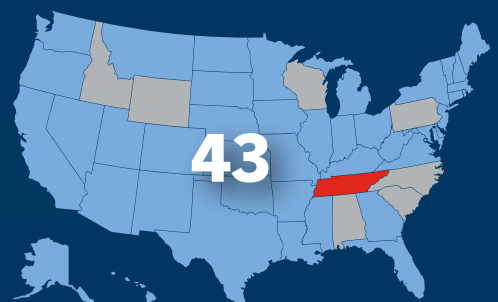
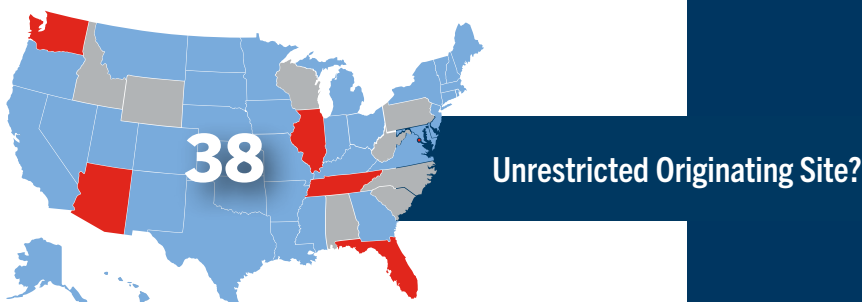
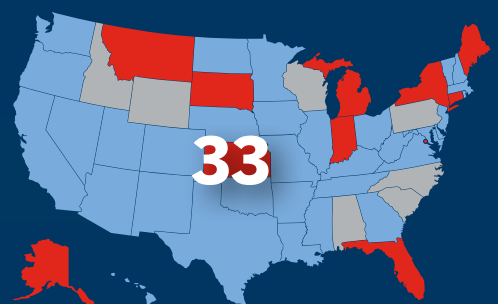
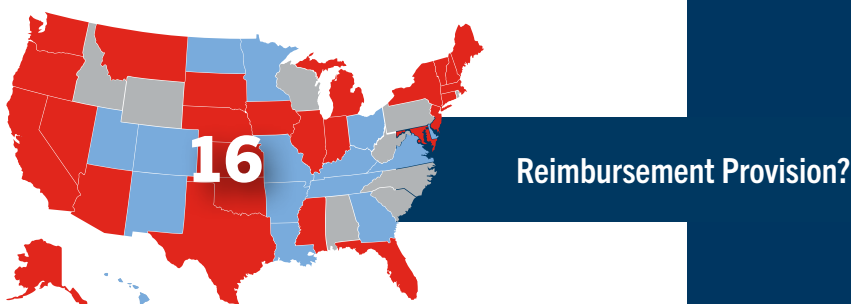
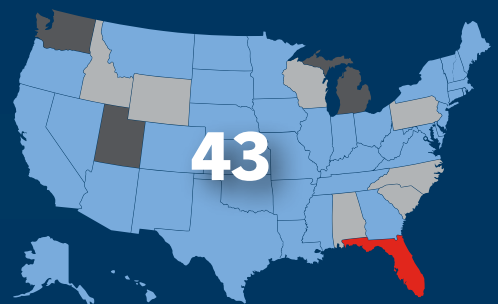
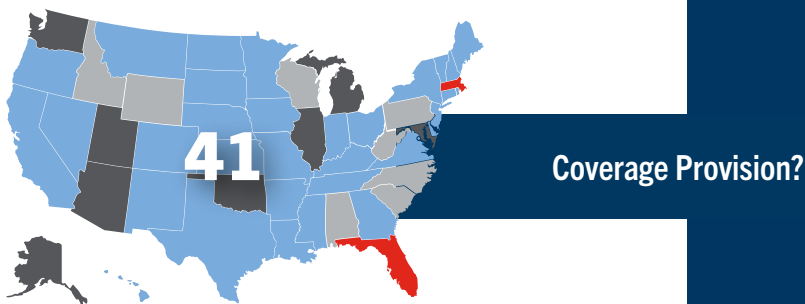
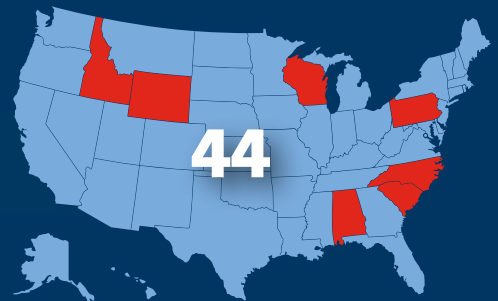
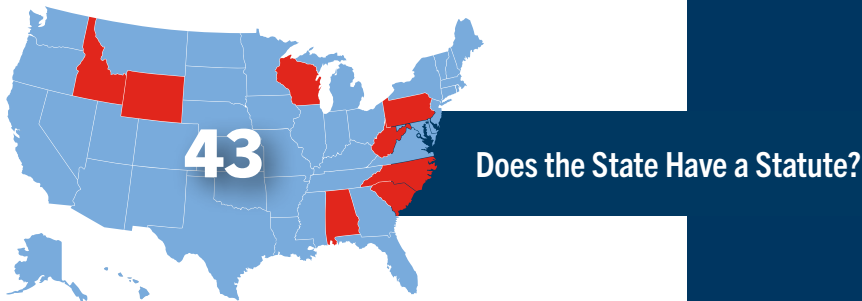
### 4. A Steady Increase in Payment Parity, But Not As Widespread

As of 2024, 33 states now have laws on payment parity or reimbursement rates, up from 16 states in 2019. That twofold increase is significant, but a closer look at the actual statutory language reveals that the many of these laws do not constitute true payment parity. Some states enacted payment parity only for mental health services. Others expressly address reimbursement, but only require health plans to reimburse providers for telemedicine services “using the proper medical codes.” Nebraska added a new reimbursement law, but it only requires payment parity if the telehealth provider also delivers in-person services at a physical location in Nebraska. Nevada’s new reimbursement provision only applies when the patient is at a qualifying originating site or FQHC or rural area. Rhode Island’s reimbursement provision limits payment parity to in-network primary care, registered dietitians/nutritionists, and behavioral health. And New York went the other way. After enacting telehealth payment parity during the PHE, New York’s statute expired on April 1, 2024 and was not renewed.

# State Telehealth Commercial Insurance Laws

**2019**

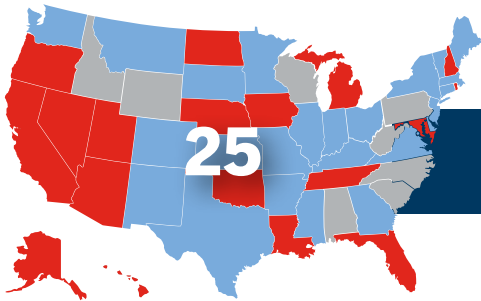
**2024**





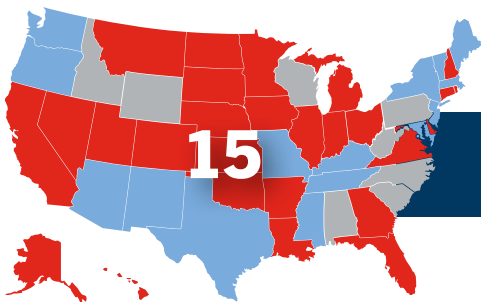
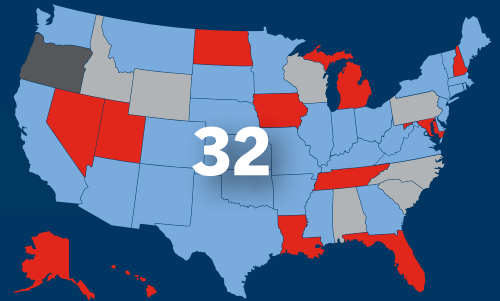
# Before and After the PHE

**2019**

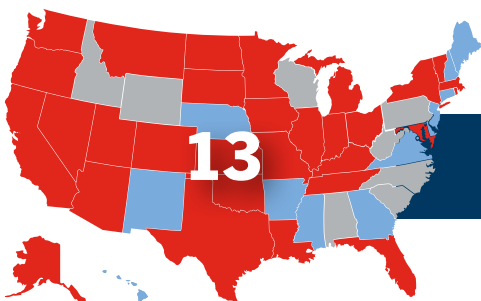
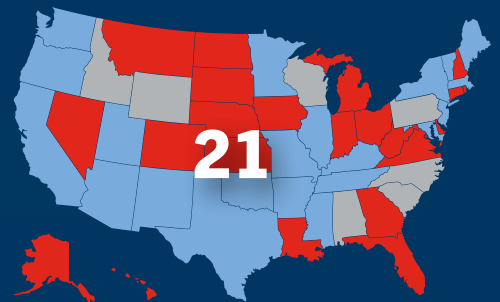


Member Cost-Shifting  
Protections?

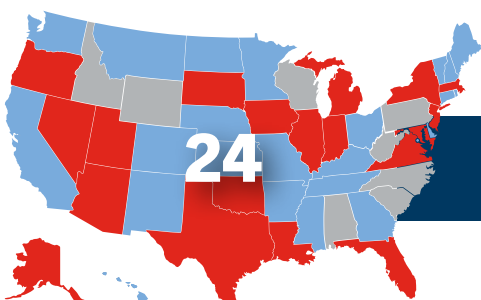
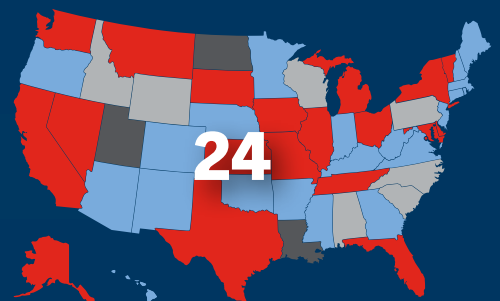
**2024**



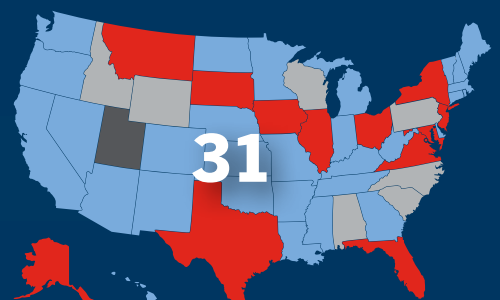
Provision for Narrow/Exclusive/  
In-Network Provider Limits?



Remote Patient Monitoring?



Store and Forward?







# State Telehealth Commercial Insurance Laws

## What Are Telehealth Commercial Coverage and Payment Parity Laws?

Currently, 43 states and DC have some sort of telehealth commercial insurance coverage law, with bills currently under development in several other states. These laws are sometimes referred to as “telehealth commercial payer statutes” or “telehealth parity laws.” They are designed to promote patient access to care via telehealth in a multitude of scenarios, whether the patient is in a rural area without specialist care, or a busy metropolitan city without time to devote three hours to travel to an in-person check-up in a crowded waiting room. There are significant variances across the states, but two related but distinct concepts have emerged: telehealth coverage and telehealth payment parity.

## Telehealth Commercial Coverage Laws

Telehealth coverage laws typically require health plans to cover services provided via telehealth to a member to the same extent the plan already covers the services for that member if the service was provided through an in-person visit. The laws do not mandate the health plan provide its members entirely new service lines or specialties, and the scope of services in the enrollee’s member benefit package remains unchanged. Nor do these laws require a health plan to provide identical coverage to any and all members — the benefits (telehealth or otherwise) still track the covered benefits under each individual member’s health benefit plan.

Assume, for example, Member A has a low-cost benefit plan with a narrow scope of 20 covered services. Member B has an expanded benefit plan with 50 covered services. A telehealth commercial coverage law would not require the health plan to cover 50 services for Member A. Member A would still enjoy coverage of only those 20 services in the benefit plan. The difference is that Member A can choose to receive those 20 services via telehealth rather than be compelled to drive to the doctor’s waiting room for an in-person consult.

For a state to promote meaningful adoption of telehealth, much depends on the language of its statute. A narrowly drawn statute may provide coverage only for telehealth and define it as licensed physician services. In that event, the telehealth market will see growth primarily in physician consults and other physician-driven health care services. If, instead, a statute is drafted more broadly to include telehealth, virtual care, and/or remote patient monitoring, the state will see growth in those areas, including equipment manufacturing, software development, and other technologies associated with virtual

care services. This could also trigger growth in companies that create patient health apps or data-driven interfaces, all of which are part of the virtual care services enterprise.

## When drafting a telehealth commercial insurance coverage law, an important decision point is whether to:

1. Cover telehealth-based services to the same extent that service is covered when provided in-person; or
2. Cover additional virtual care services, such as remote patient monitoring, even if the service is not applicable to the in-person setting.

Depending on the policy goals, different statutory language is appropriate because certain virtual care services (e.g., remote patient monitoring) do not exist in the in-person setting and will often not be a covered benefit. Some states, particularly those that have enacted telehealth coverage laws in the last few years, elected to expand telehealth coverage by also requiring health plans to cover remote patient monitoring. Remote patient monitoring includes a variety of patient oversight and communications devices, software, and processes to allow providers a greater ability to monitor patient care needs and immediately respond. States have taken this step because remote patient monitoring, by definition, is a virtual service and has no in-person equivalent that would likely already be found in a member's benefit package.

For example, if the legislature's intent is to cover a broad spectrum of virtual care services, but the bill's language reads "health plans must cover services provided via telehealth to the same extent those services are covered if provided in-person," that bill could create a coverage gap omitting remote patient monitoring because many health plans do not provide coverage for an in-person equivalent to remote patient monitoring. For this reason, some states (e.g., Mississippi) have enacted follow-up legislation to expressly expand the scope of covered virtual care services to include remote patient monitoring.

Telehealth coverage laws also frequently include language to protect patients from cost-shifting. This language disallows health plans from imposing higher or different deductibles, co-payments, or maximum benefit caps for services provided via telehealth. Any deductibles, co-payments and benefit caps apply equally and identically whether the patient receives the care in-person or via telehealth. This prevents the patient from being saddled with higher co-payments to access care via telehealth.

## Telehealth Payment Parity Laws

A subset of states with telehealth coverage laws also include language regarding reimbursement rates for telehealth services. These laws are sometimes referred to as telehealth payment parity laws. Telehealth payment parity is different from coverage. A telehealth payment parity law requires the health plan to pay the network provider for a service delivered via telehealth at the same or equivalent reimbursement rate the health plan pays that provider when the same service is delivered in-person.

Payment parity laws were created in response to health plans paying for telehealth services at only a fraction of the rate the health plan pays for the identical service when delivered in-person. This can occur when a state enacts a broad telehealth coverage law, but fails to include any language regarding the reimbursement or payment of telehealth services.

Without payment parity, a health plan could unilaterally decide to pay network providers for telehealth services at 50% of the reimbursement rate that health plan pays the provider for an identical in-person service. This is not a theoretical risk, and actually occurred when New York implemented its broad telehealth coverage law in 2016, which did not include any language regarding payment/reimbursement rates. If the health plan's payment rate is too low, it can create a disincentive for providers to offer telehealth services, undermining the very policy purposes the coverage law was intended to achieve. When this happens, in-network providers have no recourse other than to 1) offer telehealth services at a loss or 2) simply no longer offer telehealth as an option. And because the telehealth service is covered under the patient's benefit plan, the provider cannot give the patient the option to pay out-of-pocket, as doing so could be a breach of contract under the provider's participation agreement with the health plan.

Here is how payment parity works. Assume, for example, Doctor A's participation agreement with a health plan reimburses that doctor \$50 for a level 3 E/M service. Under a telehealth payment parity law, the health plan must reimburse Doctor A \$50 whether he provides that level 3 E/M service in-person or via telehealth. This is because the agreed-upon reimbursement rate under the participation agreement between Doctor A and the health plan is to pay \$50 for a level 3 E/M service to a covered member. Or if the agreed-upon contract rate for a level 2 E/M service is \$30 when delivered in-person service, the rate would be \$30 when delivered via telehealth.

Moreover, just like coverage laws, a payment parity law only affects the reimbursement rates negotiated under the participation agreement on a contract-by-contract basis. It would never require a health plan to pay all its network providers the exact same reimbursement rate. Interpreting

those laws in that way directly conflicts with how commercial health plan contracting works. For example, assume Doctor A negotiated a \$50 reimbursement rate for a level 3 E/M service under his/her participation agreement with Health Plan X. And Doctor B negotiated a \$45 reimbursement rate for a level 3 E/M service under his/her participation agreement with Health Plan X. A telehealth payment parity law would not require Health Plan X to reimburse Doctor B at \$50. Rather, Doctor B would be paid the negotiated \$45 because (unlike Medicare) commercial reimbursement rates are the result of private contract negotiations between the health plan and the provider. And if Doctor C was telehealth-only and offered no in-person services, Doctor C and Health Plan X could negotiate whatever reimbursement rates they desired because there would be no in-person rate between the parties.

Ideally, payment parity laws should not prevent the parties from negotiating for different reimbursement rates for telehealth vs in-person services, so long as such negotiations are truly voluntary by the provider and not forced upon them. Well-drafted payment parity laws can level the field for providers to enter into meaningful negotiations with health plans as to how telehealth services are covered and paid. Model payment parity laws should not eliminate opportunities for cost savings, and should allow health plans and providers to contract for alternative payment models and compensation methodologies for telehealth services, so long as those negotiations are voluntary. Nor are payment parity laws intended to prohibit health plans and providers from the freedom to develop and enter into at-risk, capitated or shared savings contracts, all of which are conducive to the benefits offered by telehealth. Keep in mind, payment parity laws do not change the health plan's existing utilization review processes. The doctor's services (whether in-person or via telehealth) must still be of high quality, appropriately documented, delivered in accordance with state medical practice standards, and medically necessary in order to be paid.

The payment parity provisions in California and Georgia statutes represent a compromise by statutorily setting payment parity as the baseline while expressly allowing providers and plans to voluntarily negotiate alternate payment rates and depart from the baseline. We include similar terms in our model legislative language (included later in this report).

## **The heat maps that follow provide a summary of the following:**

### **1. Does the State Have a Telehealth Commercial Payer Statute?**

Whether or not the state has a law addressing commercial health plan coverage of telehealth services.

### **2. Does the Law Have a Coverage Provision?**

Does the state's law expressly discuss coverage parity, meaning the law requires a commercial insurer to cover a health care service delivered via telehealth if the insurer would cover the same service if it were provided during an in-person consultation? (Variances exist among the laws and not every state has strong coverage parity, so please be sure to read the actual statutory language.)

### **3. Does the Law Have a Reimbursement Provision?**

Does the state law expressly include language addressing payment and reimbursement rates for telehealth services? For some states, this means the commercial insurer must pay the provider for a health care service delivered via telehealth at the same reimbursement rate the insurer would pay that same provider for the same service if it were delivered in-person. For other states, the reimbursement language sets a ceiling, floor, or gives instruction on how the parties must negotiate rates for telehealth services. (Variances exist among the laws and not every state has strong payment parity, so please be sure to read the actual statutory language.)

### **4. Unrestricted Originating Site?**

Does the state impose restrictions on the patient's originating site? Some states still require the patient to be located in a particular clinical setting at the time of the telehealth consultation.

### **5. Member Cost-Shifting Protections?**

Does the state have a cost-shifting protection, meaning does the state law prohibit a commercial insurer from charging a patient a deductible, coinsurance, and/or copayment for a telehealth consultation that exceeds what the insurer would charge for the same service if it were provided during an in-person consultation?

### **6. Provision for Narrow/Exclusive/In-Network Provider Limits?**

Does the state telehealth law have language addressing whether or not a health plan may limit coverage and/or reimbursement for telehealth services to only those providers that are within the plan's narrow telehealth network, exclusive network contracting, or payment provisions for in-network vs out-of-network providers? (Variances exist among the laws, so please be sure to read the actual statutory language.)

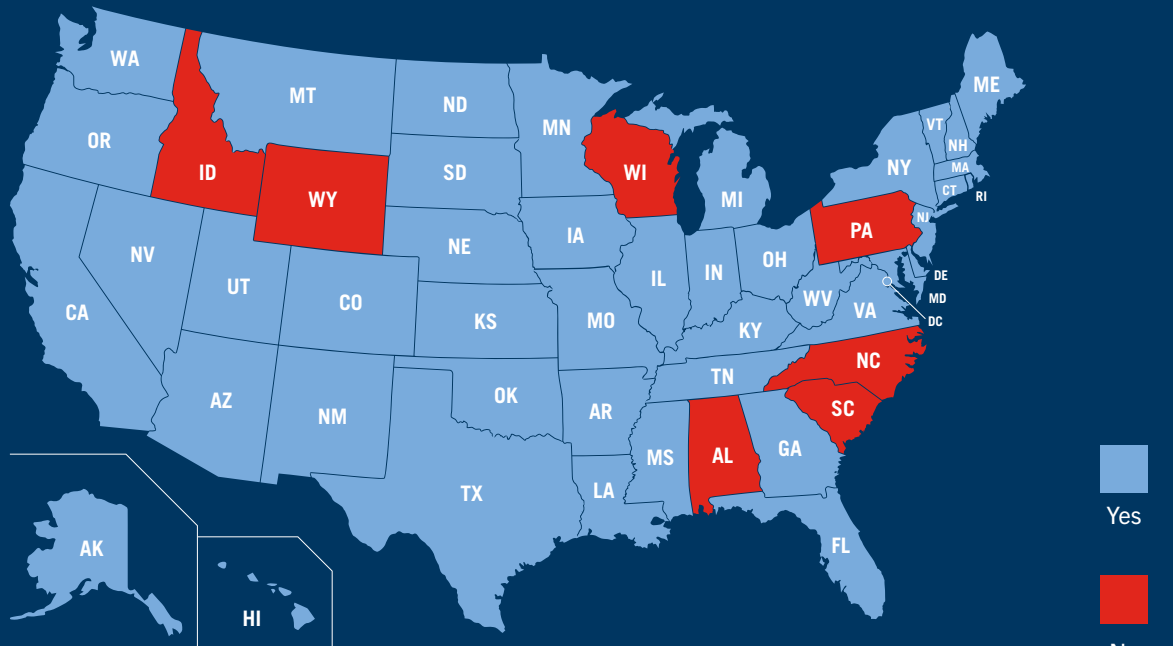
### **7. Remote Patient Monitoring (RPM)?**

Does the state require coverage of RPM services?

### **8. Store and Forward (S&F) Telehealth? Does the state require coverage of store and forward/asynchronous telehealth services?**

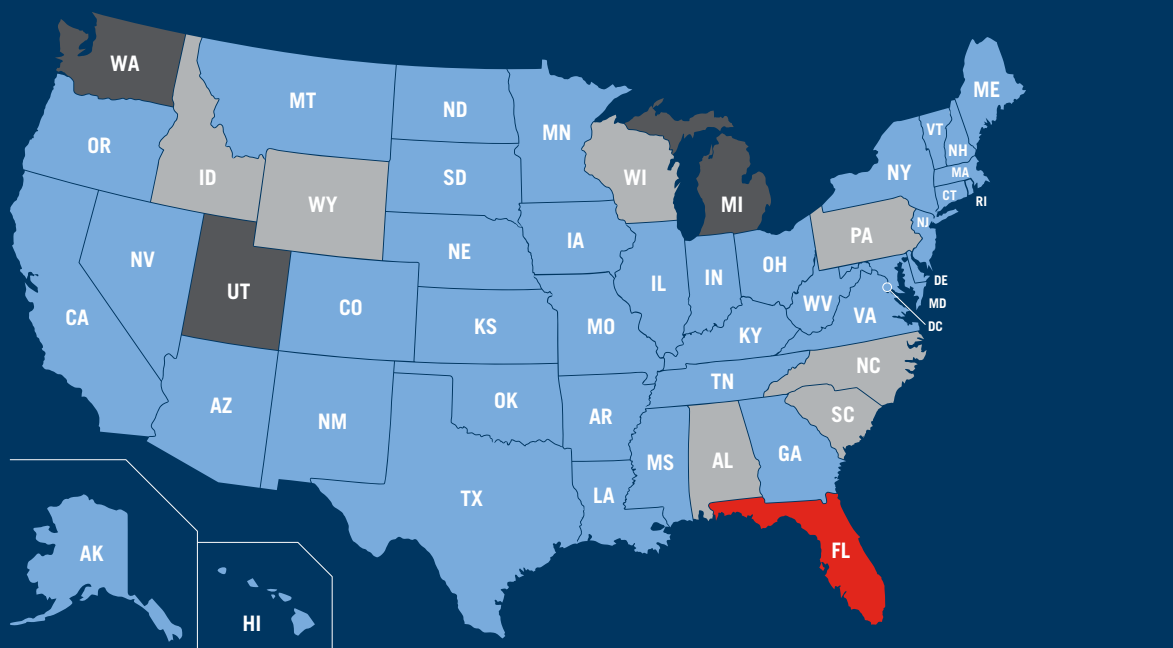
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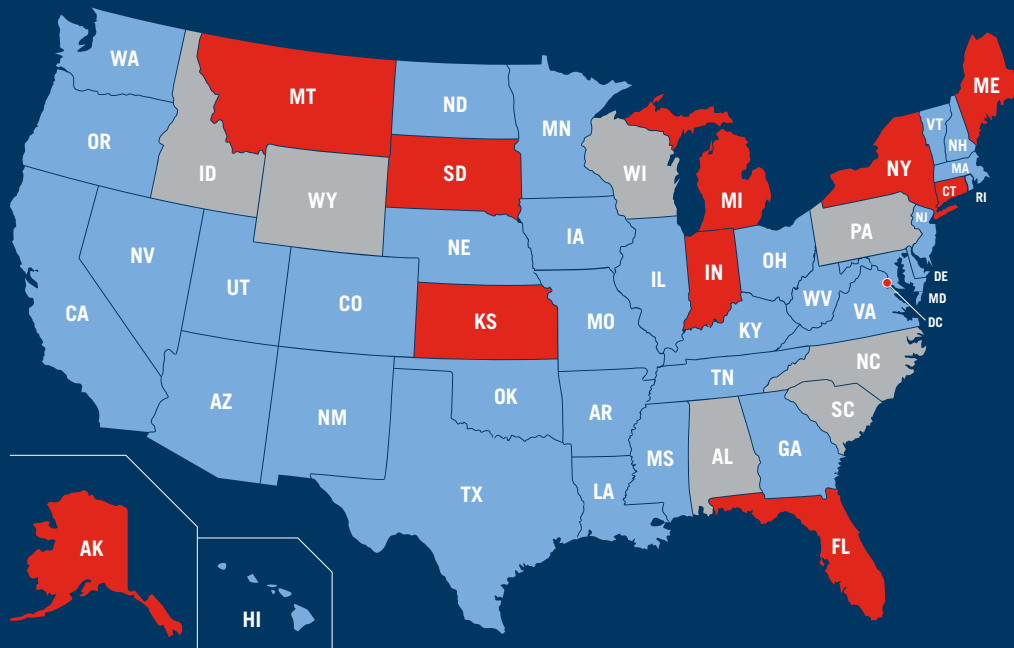
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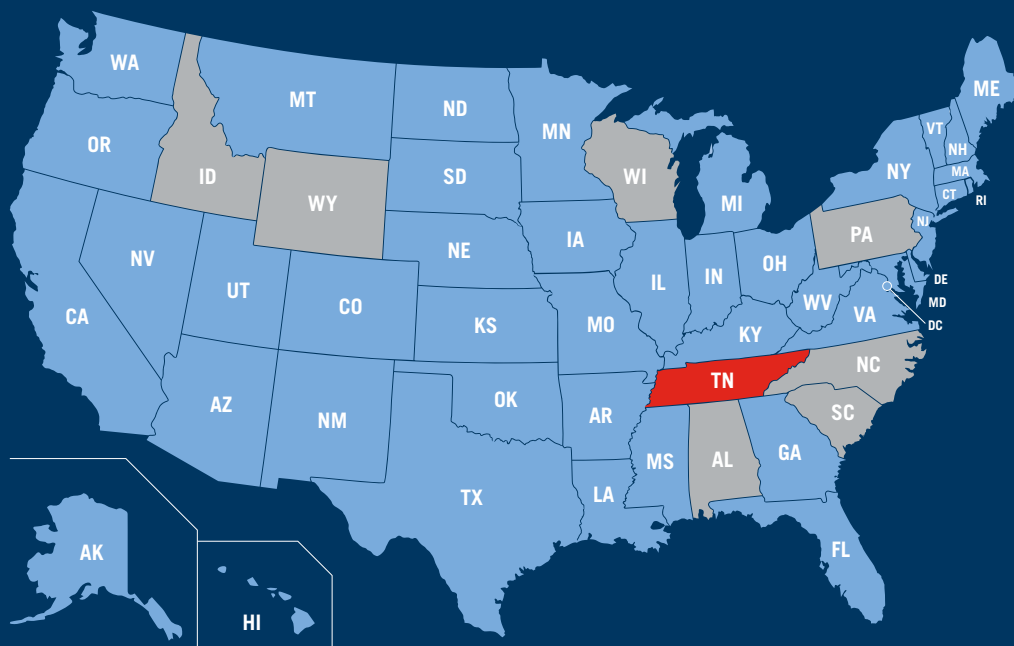
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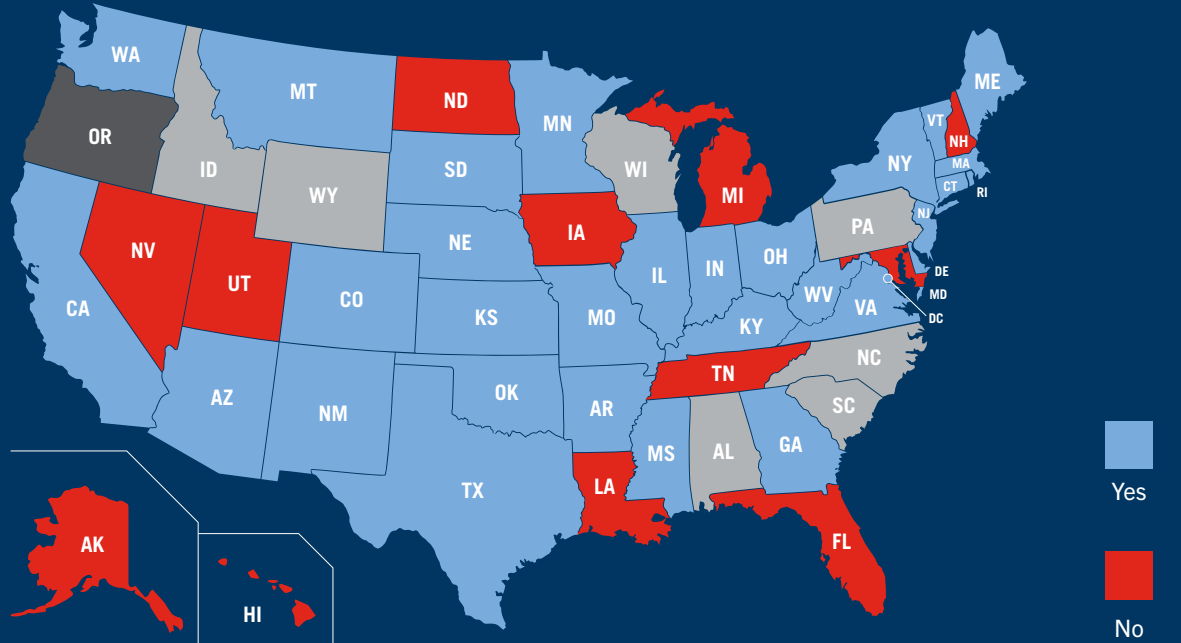
# Unrestricted Originating Site?

Does the state impose restrictions on the patient's originating site? Some states still require the patient to be located in a particular clinical setting at the time of the telehealth consultation. If the patient is permitted to be at home, we considered this a state with an unrestricted originating site.



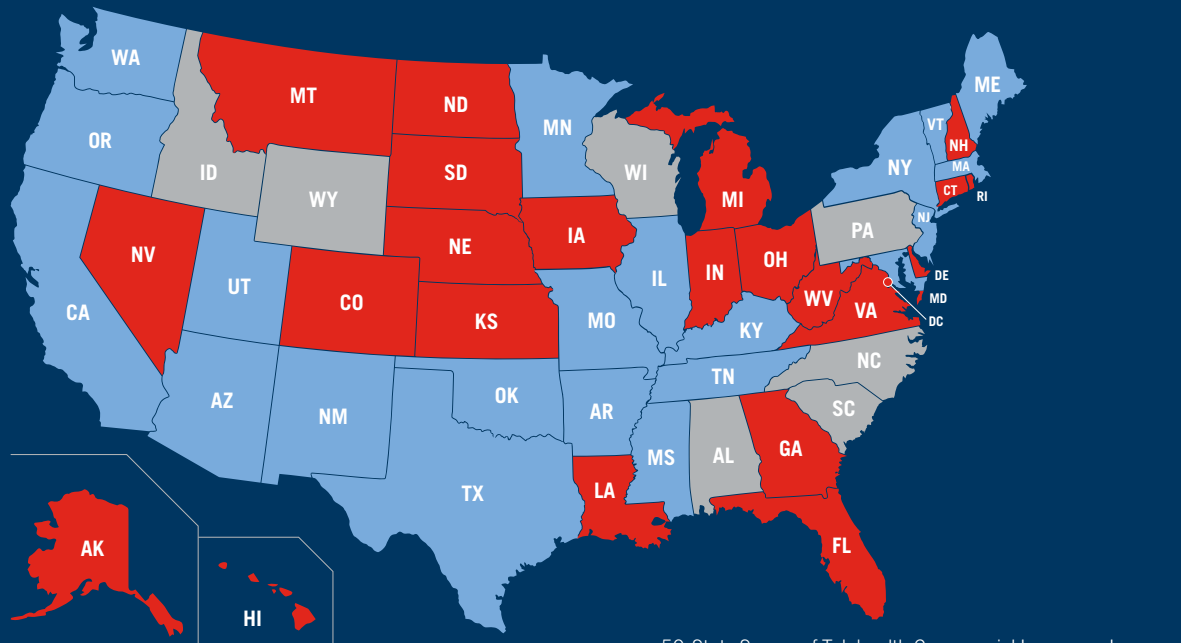
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# Provision for Narrow/Exclusive/In-Network Provider Limits?

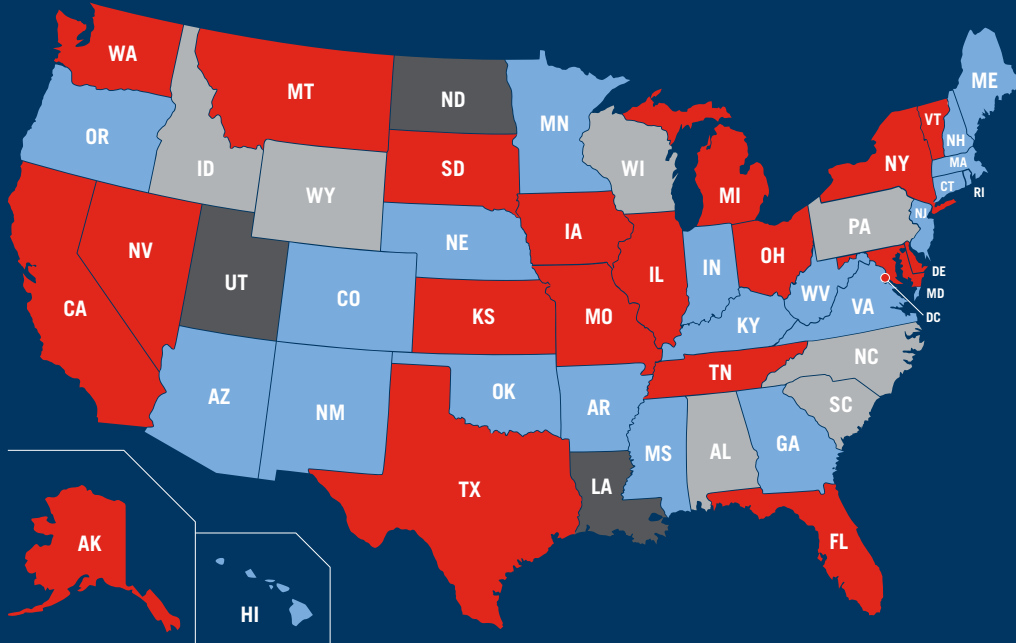
Does the state telehealth law have language addressing whether or not a health plan may limit coverage and/or reimbursement for telehealth services to only those providers that are within the plan's narrow telehealth network, exclusive network contracting, or payment provisions for in-network vs out-of-network providers? (Variances exist among the laws, so please be sure to read the actual statutory language.)





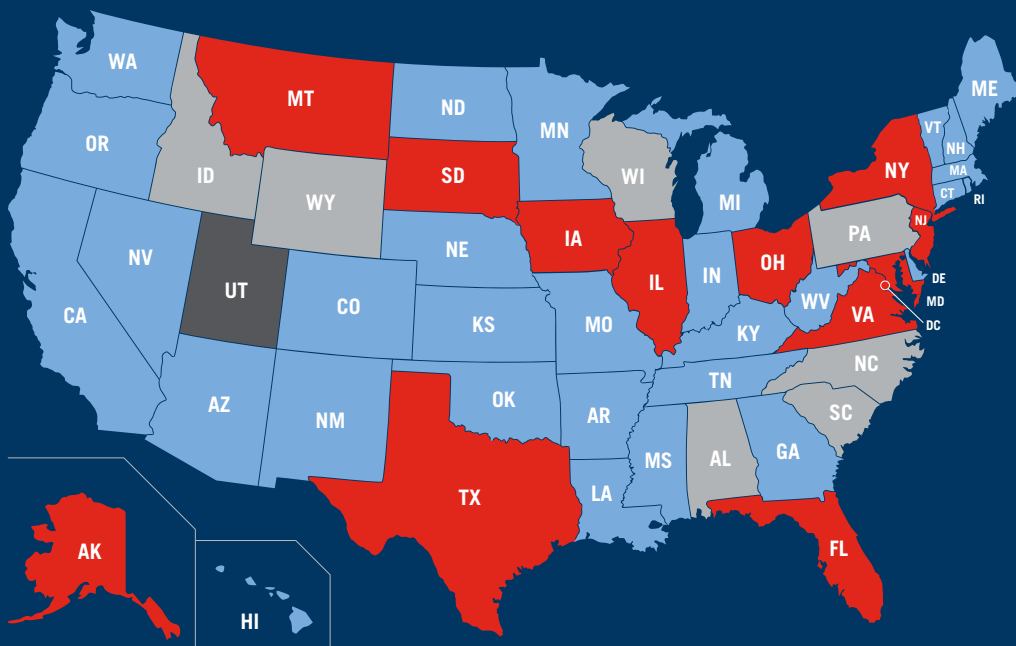
# Remote Patient Monitoring?

Does the state require coverage of RPM services?



# Store-and-Forward Telehealth?

Does the state require coverage of store and forward/asynchronous telehealth services?



# State Telehealth Commercial Payer Statutes<sup>1</sup>

The following charts and tables are an interpretive summary for informational and educational purposes only; it is not legal advice. State telehealth laws and rules are constantly changing, and must be analyzed and applied to a specific clinical application. Please be sure to reference the specific state statutes and regulations for precise legal requirements, or contact your legal counsel for guidance.

YES
  NO
  LTD LIMITED

	Does the State Have a Statute?	Coverage Provision?	Reimbursement Provision?	Unrestricted Originating Site?	Member Cost-Shifting Protections?	Provision for Narrow/ Exclusive/ In-Network Provider Limits?	Remote Patient Monitoring?	Store and Forward?	Authorities
AL	<input type="checkbox"/>	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
AK	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alaska Stat. §§ 21.42.422, 47.05.270(e)
AZ	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Ariz. Rev. Stat. §§§§ 20-841.09, 20-1406.05, 20-1057.13, 20-1376.05
AR	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Ark. Code §§ 23-79-1601, 23-79-1602
CA	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Cal. Health & Safety Code §§ 1374.13, 1374.14; Cal. Ins. Code §§ 10123.85, 10123.855; Cal. Bus. & Prof. Code § 2290.5
CO	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Colo. Rev. Stat. § 10-16-123
CT	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Conn. Gen. Stat. §§§§ 38a-499a, 38a-526a, 19a-906, 19a-906a
DE	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	18 Del. Code §§ 3370, 3571R; 18 Del. Admin. Code 1409-2.0, -3.0, -4.0
DC	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D.C. Code §§ 31-3861, 31-3862
FL	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fla. Stat. §§§ 627.42396, 641.31(45), 456.47(1)
GA	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Ga. Code § 33-24-56.4

	Does the State Have a Statute?	Coverage Provision?	Reimbursement Provision?	Unrestricted Originating Site?	Member Cost-Shifting Protections?	Provision for Narrow/ Exclusive/ In-Network Provider Limits?	Remote Patient Monitoring?	Store and Forward?	Authorities
HI	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Haw. Rev. Stat. §§§ 431:10A-116.3; 432D-23.5; 453.1.3(h), 432:1-601.5
ID	<input checked="" type="checkbox"/>	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
IL	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	215 Ill. Comp. Stat. 5/356z.22
IN	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Ind. Code § 27-8-34 et seq., 27-13- 7-22
IA	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Iowa Code §§ 514C.34, 514C.35
KS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Kan. Stat. §§ 40-2,211; 40-2,213
KY	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Ky. Rev. Stat. §§§ 211.332. 304.17A-138, 304.17A-005
LA	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	LTD	<input checked="" type="checkbox"/>	La. Stat. §§§ 22:1821, La. Stat. § 22:1841-4445, 40:1223.3; 46 La. Admin. Code Pt XLV, 7503; 37 La. Admin. Code Pt XIII, 17947.
ME	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Me. Rev. Stat. tit. 24-A, § 4316; ME Insurance Bulletin No. 459
MD	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Md. Code, Ins. § 15-139
MA	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	M.G.L.A. 175 § 47MM, 176A § 38, 176B § 25, 176G § 33, 176I § 13, 32A § 30
MI	<input checked="" type="checkbox"/>	LTD	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Mich. Comp. Laws §§ 500.3476, 550.1401k
MN	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Minn. Stat. § 62A.673
MS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Miss. Code §§ 83-9-351, 83-9-353
MO	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Mo. Stat. § 376.1900
MT	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Mont. Code § 33-22-138

	Does the State Have a Statute?	Coverage Provision?	Reimbursement Provision?	Unrestricted Originating Site?	Member Cost-Shifting Protections?	Provision for Narrow/ Exclusive/ In-Network Provider Limits?	Remote Patient Monitoring?	Store and Forward?	Authorities
NE	✓	✓	✓	✓	✓	✗	✓	✓	Neb. Rev. Stat. §§ 44-7,107; 44-312
NV	✓	✓	✓	✓	✗	✗	✗	✓	Nev. Rev. Stat. § 689A.0463; Nev. Rev. Stat. § 689B.0369; Nev. Rev. Stat. § 689C.195; Nev. Rev. Stat. § 616C.730; Nev. Rev. Stat. § 695A.265; Nev. Rev. Stat. § 695B.1904; Nev. Rev. Stat. § 695C.1708; Nev. Rev. Stat. § 695D.216; Nev. Rev. Stat. § 695G.162; Nev. Rev. Stat. § 629.515.
NH	✓	✓	✓	✓	✗	✗	✓	✓	N.H. Rev. Stat. §§ 415-J:2, 415-J:3, 420-J:8-e
NJ	✓	✓	✓	✓	✓	✓	✓	✗	N.J. Stat. §§ 26:2S-29, 52:14-17.29w, 52:14-17.46.6h, 45:1-61
NM	✓	✓	✓	✓	✓	✓	✓	✓	N.M. Stat. § 13-7-14; N.M. Stat. § 59A-46-50.3; N.M. Stat. § 59A-22-49.3; N.M. Stat. § 59A-23-7.12; N.M. Stat. § 59A-47-45.3
NY	✓	✓	✗	✓	✓	✓	✗	✗	N.Y. Ins. Law § 3217-h; N.Y. Ins. Law § 4306-g; N.Y. Pub. Health Law § 4406-g
NC	✗	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
ND	✓	✓	✓	✓	✗	✗	LTD	✓	N.D. Cent. Code § 26.1-36-09.15
OH	✓	✓	✓	✓	✓	✗	✗	✗	Ohio Rev. Code § 3902.30; Ohio Rev. Code § 4743.09
OK	✓	✓	✓	✓	✓	✓	✓	✓	36 Okla. St. §§ 6802, 6803
OR	✓	✓	✓	✓	LTD	✓	✓	✓	Or. Rev. Stat. §§§§ 743A.012, 743A.058, 743A.168, 743A.185
PA	✗	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
RI	✓	✓	✓	✓	✓	✗	✓	✓	R.I. Gen. Laws §§ 27-81-3, 27-81-4
SC	✗	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
SD	✓	✓	✗	✓	✓	✗	✗	✗	S.D. Codified Laws §§ 58-17-167, -168, -169, -170
TN	✓	✓	✓	✗	✗	✓	✗	✓	Tenn. Code §§ 56-7-1002, -1003, -1011, -1012
TX	✓	✓	✓	✓	✓	✓	✗	✗	Tex. Ins. Code §§ 1455.001– 1455.004, 1455.006; Tex. Occ. Code § 111.001

	Does the State Have a Statute?	Coverage Provision?	Reimbursement Provision?	Unrestricted Originating Site?	Member Cost-Shifting Protections?	Provision for Narrow/Exclusive/In-Network Provider Limits?	Remote Patient Monitoring?	Store and Forward?	Authorities
UT	✓	LTD	✓	✓	✗	✓	LTD	LTD	Utah Code §§ 31A-22-649.5, 31A-22- 649, 26B-4-704
VT	✓	✓	✓	✓	✓	✓	✗	✓	8 Vt. Stat. § 4100k, § 4100l
VA	✓	✓	✓	✓	✓	✗	✓	✗	Va. Code § 38.2-3418.16
WA	✓	LTD	✓	✓	✓	✓	✗	✓	Wash. Rev. Code §§ 48.43.735, 41.05.700, 71.24.335
WV	✓	✓	✓	✓	✓	✗	✓	✓	W. Va. Code §§ 33-57-1, 5-16-7b
WI	✗	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
WY	✗	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None

<sup>1</sup> Our research was last comprehensively conducted from February 2024 through April 2024, and the authorities could be amended at a later date. State laws and rules are constantly changing, so be certain to reference and read the statutes and regulations for precise legal requirements. Please note some states have multiple telehealth coverage laws applicable to various policy, service, and/or provider types. Our interpretive tables apply the most general coverage provision and/or the predominant answer across the state, but there may be variances across coverage laws in the state so please be certain to refer to the precise legal requirements.

# Telehealth Commercial Insurance Coverage Model

## Statutory Language to Consider

**Same Coverage:** “A health insurance contract that is delivered, issued for delivery, or renewed in this state shall provide coverage for health care services delivered via telehealth to the same extent the services would be covered if delivered via an in-person encounter.”

**Same Reimbursement (payment parity but allowing for contract negotiations):** “For purposes of reimbursement and payment, a health insurer shall compensate the health care provider for services delivered via telehealth on the same basis and at the same payment rate the health insurer would apply to the services if the services had been delivered via an in-person encounter by the health care provider. Nothing in this section is intended to limit the ability of a health insurer and a health care provider to voluntarily negotiate alternate payment rates for health care services delivered via telehealth. Nothing in this section is intended to require reimbursement for services delivered via telehealth to be unbundled from other capitated or bundled, risk-based payments.”

**Equitable Reimbursement (but not payment parity):** “For purposes of reimbursement and payment, a health insurer shall compensate the health care provider for services delivered via telehealth at a fair payment rate that also takes into consideration the ongoing investment necessary to ensure these telehealth platforms are continuously maintained, seamlessly updated, and services can continue to expand as needed.”

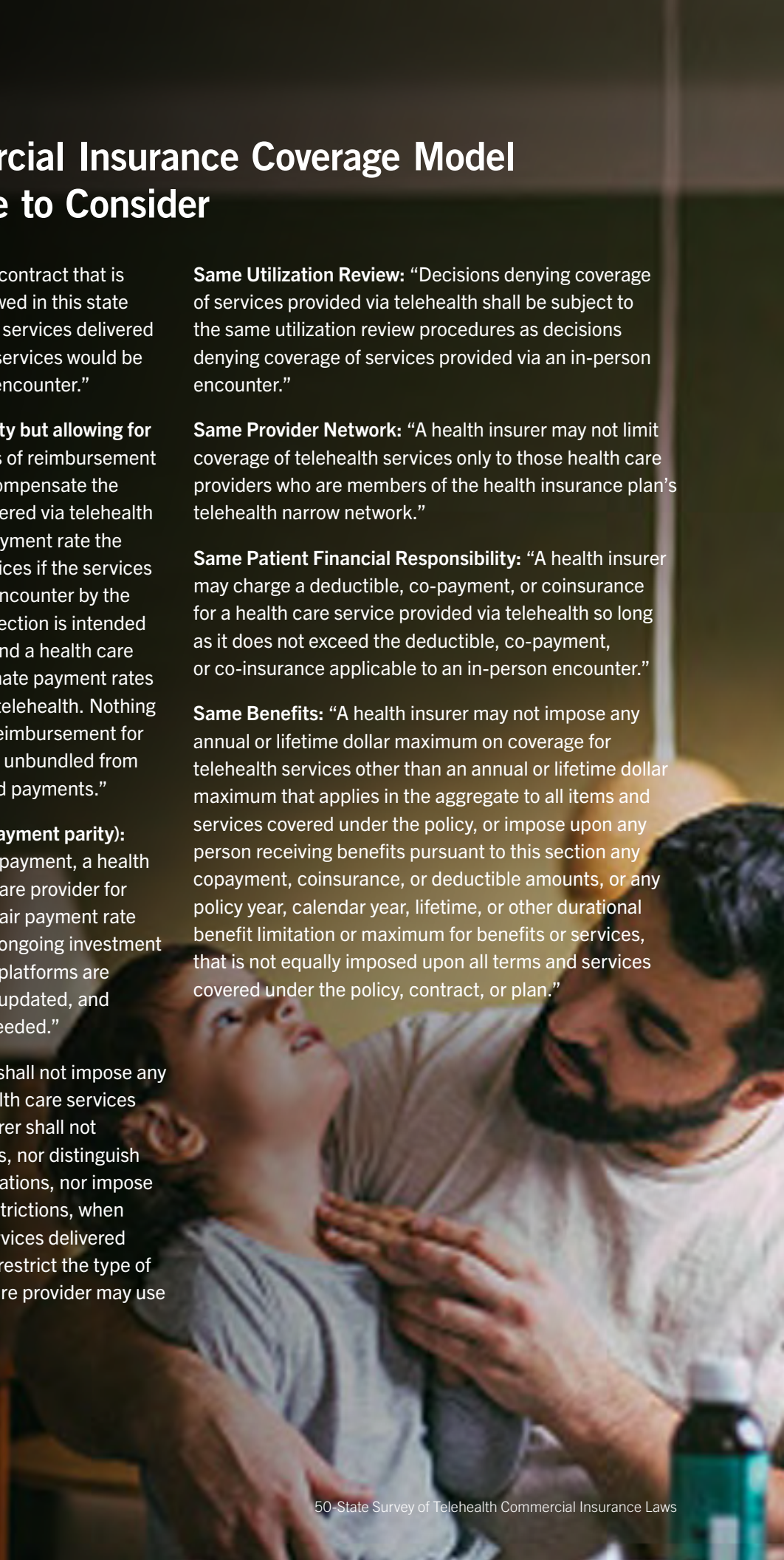
**Same Restrictions:** “A health insurer shall not impose any unique conditions for coverage of health care services delivered via telehealth. A health insurer shall not impose any originating site restrictions, nor distinguish between patients in rural or urban locations, nor impose any geographic or distance-based restrictions, when providing coverage for health care services delivered via telehealth. A health plan shall not restrict the type of telehealth technology that a health care provider may use to deliver services.

**Same Utilization Review:** “Decisions denying coverage of services provided via telehealth shall be subject to the same utilization review procedures as decisions denying coverage of services provided via an in-person encounter.”

**Same Provider Network:** “A health insurer may not limit coverage of telehealth services only to those health care providers who are members of the health insurance plan’s telehealth narrow network.”

**Same Patient Financial Responsibility:** “A health insurer may charge a deductible, co-payment, or coinsurance for a health care service provided via telehealth so long as it does not exceed the deductible, co-payment, or co-insurance applicable to an in-person encounter.”

**Same Benefits:** “A health insurer may not impose any annual or lifetime dollar maximum on coverage for telehealth services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.”



## TABLE OF CONTENTS

---

24	Alabama	92	Kentucky	178	North Dakota
26	Alaska	96	Louisiana	182	Ohio
28	Arizona	106	Maine	184	Oklahoma
36	Arkansas	110	Maryland	188	Oregon
40	California	114	Massachusetts	198	Pennsylvania
46	Colorado	118	Michigan	200	Rhode Island
50	Connecticut	120	Minnesota	204	South Carolina
54	Delaware	124	Mississippi	206	South Dakota
60	District of Columbia	130	Missouri	210	Tennessee
62	Florida	134	Montana	218	Texas
64	Georgia	138	Nebraska	222	Utah
68	Hawaii	142	Nevada	226	Vermont
74	Idaho	154	New Hampshire	230	Virginia
76	Illinois	158	New Jersey	234	Washington
80	Indiana	164	New Mexico	242	West Virginia
84	Iowa	172	New York	246	Wisconsin
88	Kansas	176	North Carolina	248	Wyoming

## ALABAMA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A



# Alabama

There are currently no commercial payer telehealth statutes in this state.



## ALASKA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A



# Alaska

**Authorities: Alaska Stat. §§ 21.42.422, 47.05.270(e)**

## Alaska Stat. § 21.42.422

### *Coverage for telehealth*

(a) A health care insurer that offers, issues for delivery, or renews in the state a health care insurance plan in the group or individual market shall provide coverage for benefits provided through telehealth by a health care provider licensed in this state and may not require that prior in-person contact occur between a health care provider and a patient before payment is made for covered services.

(b) In this section,

(1) “health care insurer” means a person transacting the business of health care insurance, including an insurance company licensed under AS 21.09, a hospital or medical service corporation licensed under AS 21.87, a fraternal benefit society licensed under AS 21.84, a health maintenance organization licensed under AS 21.86, the Comprehensive Health Insurance Association described in AS 21.55.010, a multiple employer welfare arrangement, a church plan, and a governmental plan, except for a nonfederal governmental plan that elects to be excluded under 42 U.S.C. 300gg-21(a)(2) (Health Insurance Portability and Accountability Act of 1996);

(2) “telehealth” has the meaning given in AS 47.05.270(e).

## Alaska Stat. § 47.05.270(e)

Medical assistance reform program (defining telehealth)

[...]

(e) In this section, “telehealth” means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the recipient or from each other or between a provider and a recipient who are physically separated from each other.

## ARIZONA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Arizona

**Authorities: Ariz. Rev. Stat. §§ 20-841.09 (for hospital, medical, dental, and optometric service corporations), 20-1406.05 (for group and blanket disability insurance), 20-1057.13 (for health care services organizations), 20-1376.05 (for disability insurance)**

## **Ariz. Rev. Stat. § 20-841.09**

*Hospital, Medical, Dental and Optometric Service Corporations—Telehealth; coverage of health care services; definitions*

A. All contracts issued, delivered or renewed in this state must provide coverage for health care services that are provided through telehealth if the health care service would be covered were it provided through an in-person encounter between the subscriber and a health care provider and provided to a subscriber receiving the service in this state. The following requirements apply to coverage of telehealth services:

1. Except as otherwise provided in this subsection, a corporation may not limit or deny the coverage of health care services provided through telehealth, including ancillary services, and may apply only the same limits or exclusions on a health care service provided through telehealth that are applicable to an in-person encounter for the same health care service, except for procedures or services for which the weight of evidence, based on practice guidelines, peer-reviewed clinical publications or research or recommendations by the telehealth advisory committee on telehealth best practices established by § 36-3607, determines not to be appropriate to be provided through telehealth.

2. Except as otherwise provided in this paragraph, a corporation shall reimburse health care providers at the same level of payment for equivalent service as identified by the healthcare common procedure coding system, whether provided through telehealth using an audio-visual format or in-person care. A corporation shall reimburse health care providers at the same level of payment for equivalent in-person behavioral health and substance use disorder services as identified by the healthcare common procedure coding system if provided through telehealth using an audio-only format. This paragraph does not apply to a telehealth encounter provided through a telehealth platform that is sponsored or provided by the corporation. A corporation may not require a health care provider to use a telehealth platform that is sponsored or provided by the corporation as a condition of network participation.

3. Before January 1, 2022, corporation shall cover services provided through an audio-only telehealth encounter if that service is covered by medicare or the Arizona health care cost containment system when provided through an audio-only telehealth encounter. Beginning January 1, 2022, a corporation shall cover services provided through an audio-only telehealth encounter if the telehealth advisory committee on telehealth best practices established by § 36-3607 recommends that the services may appropriately be provided through an audio-only telehealth encounter.

4. A health care provider shall bill for a telehealth encounter using the healthcare common procedure coding system and shall identify whether the telehealth encounter was provided in an audio-only or audio-video format. To submit a claim for an audio-only services, the health care provider must make telehealth services generally available to patients through the interactive use of audio, video or other electronic media.

5. At the time of the telehealth encounter, the health care provider shall access clinical information and records, if available, that are appropriate to evaluate the patient's condition. The health care provider shall inform the subscriber before the telehealth encounter if there is a charge for the encounter.

6. A corporation may establish reasonable requirements and parameters for telehealth services, including documentation, fraud prevention, identity verification and recordkeeping, but such requirements and parameters may not be more restrictive or less favorable to health care providers or subscribers than are required for health care services delivered in person.

7. Covered telehealth services may be provided regardless of where the subscriber is located or the type of site.

8. Except in an emergency as prescribed in § 20-2803, the contract may limit the coverage to those health care providers who are members of the corporation's provider network.

B. Subsection A of this section does not:

1. Limit the ability of corporations to provide incentives to subscribers that are designed to improve health outcomes, increase adherence to a course of treatment or reduce risk.
2. Prevent corporations from offering network contracts to health care providers who employ value-based purchasing or bundled payment methodologies if otherwise allowed by law or prevent health care providers from voluntarily agreeing to enter into such contracts with a corporation.

C. This section does not relieve a corporation from an obligation to provide adequate access to in-person health care services. Network adequacy standards required by federal or state law may not be met by a corporation through the use of contracted health care providers who provide only telehealth services and do not provide in-person health care services in this state or within fifty miles of the border of this state.

D. This section does not prevent a corporation from imposing deductibles or copayment or coinsurance requirements for a health care service provided through telehealth if the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person encounter for the same health care service. If the corporation waives a deductible or copayment or coinsurance requirement that impacts a health care provider's contracted reimbursement rate, the corporation shall reimburse the health care provider for the cost of the deductible or copayment or coinsurance requirement to ensure that the health care provider receives the contracted reimbursement rate if the service is covered and the claim meets other requirements of the network participation agreement.

E. Services provided through telehealth or resulting from a telehealth encounter are subject to all of this state's laws and rules that govern prescribing, dispensing and administering prescription pharmaceuticals and devices and shall comply with Arizona licensure requirements and any practice guidelines of the telehealth advisory committee on telehealth best practices established by § 36-3607 or, if not addressed, the practice guidelines of a national association of medical professionals promoting access to medical care for consumers via telecommunications technology or other qualified medical professional societies to ensure quality of care.

F. This section does not apply to limited benefit coverage as defined in § 20-1137.

G. For the purposes of this section, "telehealth":

1. Means the interactive use of audio, video or other electronic media, including asynchronous store-and-forward technologies and remote patient monitoring technologies, for the purpose of diagnosis, consultation or treatment.

2. Includes:

(a) The use of an audio-only telephone encounter between a subscriber who has an existing relationship with healthcare provider or provider group if both of the following apply:

(i) An audio-visual telehealth encounter is not reasonably available due to the subscriber's functional status, the subscriber's lack of technology or telecommunications infrastructure limits, as determined by the health care provider.

(ii) The telehealth encounter is initiated at the request of the subscriber or authorized by the subscriber before the telehealth encounter.

(b) The use of an audio-only encounter between the subscriber and a health care provider, regardless of whether there is an existing relationship with the health care provider or provider group, if the telehealth encounter is for a behavioral health or substance use disorder service and both items of subdivision (a) of this paragraph apply.

3. Does not include the sole use of a fax machine, instant messages, voice mail or email.

#### **Ariz. Rev. Stat. § 20-1406.05**

*Group and Blanket Disability Insurance—Telehealth; coverage of health care services; definitions*

A. All policies issued, delivered or renewed by a group disability insurer or a blanket disability insurer in this state must provide coverage for health care services that are provided through telehealth if the health care service would be covered were it provided through an in-person encounter between the insured and a health care provider and provided to an insured receiving the service in this state. The following apply to coverage of telehealth services:

1. Except as otherwise provided in this subsection, a group or blanket disability insurer may not limit or deny the coverage of health care services provided through telehealth, including ancillary services, and may apply only the same limits or exclusions on a health care service provided through telehealth that are applicable to an in-person encounter for the same

health care service, except for procedures or services for which the weight of evidence, based on practice guidelines, peer-reviewed clinical publications or research or recommendations by the telehealth advisory committee on telehealth best practices established by § 36-3607, determines not to be appropriate to be provided through telehealth.

2. Except as otherwise provided in this paragraph, a group or blanket disability insurer shall reimburse health care providers at the same level of payment for equivalent services as identified by the healthcare common procedure coding system, whether provided through telehealth using an audio-visual format or in-person care. A group or blanket disability insurer shall reimburse health care providers at the same level of payment for equivalent in-person behavioral health and substance use disorder services as identified by the healthcare common procedure coding system if provided through telehealth using an audio-only format. This paragraph does not apply to a telehealth encounter provided through a telehealth platform that is sponsored or provided by the group or blanket disability insurer. A group or blanket disability insurer may not require a health care provider to use a telehealth platform that is sponsored or provided by the group or blanket disability insurer as a condition of network participation.

3. Before January 1, 2022, a group or blanket disability insurer shall cover services provided through an audio-only telehealth encounter if that service is reimbursed by medicare or the Arizona health care cost containment system when provided through an audio-only telehealth encounter. Beginning January 1, 2022, a group or blanket disability insurer shall cover services provided through an audio-only telehealth encounter if the telehealth advisory committee on telehealth best practices established by § 36-3607 recommends that the services may appropriately be provided through an audio-only telehealth encounter.

4. A health care provider shall bill for a telehealth encounter using the healthcare common procedure coding system and shall identify whether the telehealth encounter was provided in an audio-only or audio-video format. To submit a claim for an audio-only service, the health care provider must make telehealth services generally available to patients through the interactive use of audio, video or other electronic media.

5. At the time of the telehealth encounter, the health care provider shall access clinical information and records, if available, that are appropriate to evaluate

the patient's condition. The health care provider shall inform the insured before the telehealth encounter if there is a charge for the encounter.

6. A group or blanket disability insurer may establish reasonable requirements and parameters for telehealth services, including documentation, fraud prevention, identity verification and recordkeeping, but such requirements and parameters may not be more restrictive or less favorable to health care providers or insureds than are required for health care services delivered in person.

7. Covered telehealth services may be provided regardless of where the insured is located or the type of site.

8. Except in an emergency as prescribed in § 20-2803, the policy may limit the coverage to those health care providers who are members of the insurer's provider network.

B. Subsection A of this section does not:

1. Limit the ability of group or blanket disability insurers to provide incentives to insureds that are designed to improve health outcomes, increase adherence to a course of treatment or reduce risk.

2. Prevent group or blanket disability insurers from offering network contracts to health care providers who employ value-based purchasing or bundled payment methodologies if otherwise allowed by law or prevent health care providers from voluntarily agreeing to enter into such contracts with a group or blanket disability insurer.

C. This section does not relieve a group or blanket disability insurer from an obligation to provide adequate access to in-person health care services. Network adequacy standards required by federal or state law may not be met by a group or blanket disability insurer through the use of contracted health care providers who provide only telehealth services and do not provide in-person health care services in this state or within fifty miles of the border of this state.

D. This section does not prevent a group or blanket disability insurer from imposing deductibles or copayment or coinsurance requirements for a health care service provided through telehealth if the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person encounter for the same health care service. If the group or blanket disability insurer waives a deductible or copayment or coinsurance requirement that impacts a health care

provider's contracted reimbursement rate, the group or blanket disability insurer shall reimburse the health care provider for the cost of the deductible or copayment or coinsurance requirement to ensure that the health care provider receives the contracted reimbursement rate if the service is covered and the claim meets other requirements of the network participation agreement.

E. Services provided through telehealth or resulting from a telehealth encounter are subject to all of this state's laws and rules that govern prescribing, dispensing and administering prescription pharmaceuticals and devices and shall comply with Arizona licensure requirements and any practice guidelines of the telehealth advisory committee on telehealth best practices established by § 36-3607 or, if not addressed, the practice guidelines of a national association of medical professionals promoting access to medical care for consumers via telecommunications technology or other qualified medical professional societies to ensure quality of care.

F. This section does not apply to limited benefit coverage as defined in § 20-1137.

G. For the purposes of this section, "telehealth":

1. Means the interactive use of audio, video or other electronic media, including asynchronous store-and-forward technologies and remote patient monitoring technologies, for the purpose of diagnosis, consultation or treatment.

2. Includes:

(a) The use of an audio-only telephone encounter between an insured who has an existing relationship with a health care provider or provider group if both of the following apply:

(i) An audio-visual telehealth encounter is not reasonably available due to the insured's functional status, the insured's lack of technology or telecommunications infrastructure limits, as determined by the health care provider.

(ii) The telehealth encounter is initiated at the request of the insured or authorized by the insured before the telehealth encounter.

(b) The use of an audio-only encounter between the insured and a health care provider, regardless of whether there is an existing relationship with the health care provider or provider group, if the telehealth encounter is for a behavioral health or substance

use disorder service and both items of subdivision (a) of this paragraph apply.

3. Does not include the sole use of a fax machine, instant messages, voice mail or email.

### **Ariz. Rev. Stat. § 20-1057.13**

*Health Care Services Organizations— Telehealth; coverage of health care services; definition*

A. An evidence of coverage issued, delivered or renewed by a health care services organization in this state must provide coverage for health care services that are provided through telehealth if the health care service would be covered were it provided through an in-person encounter between the enrollee and a health care provider and provided to an enrollee receiving the service in this state. The following requirements apply to coverage of telehealth services:

1. Except as otherwise provided in this subsection, a health care services organization may not limit or deny the coverage of health care services provided through telehealth, including ancillary services, and may apply only the same limits or exclusions on a health care service provided through telehealth that are applicable to an in-person encounter for the same health care service, except for procedures or services as identified by the diagnostic and procedure codes, for which the weight of evidence, based on practice guidelines, peer-reviewed clinical publications or research or recommendations by the telehealth advisory committee on telehealth best practices established by § 36-3607, determines not to be appropriate to be provided through telehealth.

2. Except as otherwise provided in this paragraph, a health care services organization shall reimburse health care providers at the same level of payment for equivalent services as identified by the healthcare common procedure coding system, whether provided through telehealth using an audio-visual format or in-person care. A health care services organization shall reimburse health care providers at the same level of payment for equivalent in-person behavioral health and substance use disorder services as identified by the healthcare common procedure coding system if provided through telehealth using an audio-only format. This paragraph does not apply to a telehealth encounter provided through a telehealth platform that is sponsored or provided by the health care services organization. A health care services organization may not require a health care provider to use a telehealth



platform that is sponsored or provided by the health care services organization as a condition of network participation.

3. Before January 1, 2022, a health care services organization shall cover services provided through an audio-only telehealth encounter if that service is covered by medicare or the Arizona health care cost containment system when provided through an audio-only telehealth encounter.

4. A health care provider shall bill for a telehealth encounter using the healthcare common procedure coding system and shall identify whether the telehealth encounter was provided in an audio-only or audio-video format. To submit a claim for an audio-only service, the health care provider must make telehealth services generally available to patients through the interactive use of audio, video or other electronic media.

5. At the time of the telehealth encounter, the health care provider shall access clinical information and records, if available, that are appropriate to evaluate the patient's condition. The health care provider shall inform the enrollee before the telehealth encounter if there is a charge for the encounter.

6. A health care services organization may establish reasonable requirements and parameters for telehealth services, including documentation, fraud prevention, identity verification and recordkeeping, but such requirements and parameters may not be more restrictive or less favorable to health care providers or enrollees than are required for health care services delivered in person.

7. Covered telehealth services may be provided regardless of where the enrollee is located or the type of site.

8. Except in an emergency as prescribed in § 20-2803, the evidence of coverage may limit the coverage to those health care providers who are members of the health care services organization's provider network.

B. Subsection A of this section does not:

1. Limit the ability of health care services organizations to provide incentives to enrollees that are designed to improve health outcomes, increase adherence to a course of treatment or reduce risk.

2. Prevent health care services organizations from offering network contracts to health care providers who employ value-based purchasing or bundled payment methodologies if otherwise allowed by law or

prevent health care providers from voluntarily agreeing to enter into such contracts with a health care services organization.

C. This section does not relieve a health care services organization from an obligation to provide adequate access to in-person health care services. Network adequacy standards required by federal or state law may not be met by a health care services organization through the use of contracted health care providers who provide only telehealth services and do not provide in-person health care services in this state or within fifty miles of the border of this state.

D. This section does not prevent a health care services organization from imposing deductibles or copayment or coinsurance requirements for a health care service provided through telehealth if the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person encounter for the same health care service. If the health care services

organization waives a deductible or copayment or coinsurance requirement that impacts a health care provider's contracted reimbursement rate, the health care services organization shall reimburse the health care provider for the cost of the deductible or copayment or coinsurance requirement to ensure that the health care provider receives the contracted reimbursement rate if the service is covered and the claim meets other requirements of the network participation agreement.

E. Services provided through telehealth or resulting from a telehealth encounter are subject to all of this state's laws and rules that govern prescribing, dispensing and administering prescription pharmaceuticals and devices and shall comply with Arizona licensure requirements and any practice guidelines of the telehealth advisory committee on telehealth best practices established by § 36-3607 or, if not addressed, the practice guidelines of a national association of medical professionals promoting access to medical care for consumers via telecommunications technology or other qualified medical professional societies to ensure quality of care.

F. This section does not apply to limited benefit coverage as defined in § 20-1137.

G. For the purposes of this section, "telehealth":

1. Means the interactive use of audio, video or other electronic media, including asynchronous store-and-forward technologies and remote patient monitoring

technologies, for the purpose of diagnosis, consultation or treatment.

2. Includes:

(a) The use of an audio-only telephone encounter between an enrollee who has an existing relationship with a health care provider or provider group if both of the following apply:

(i) An audio-visual telehealth encounter is not reasonably available due to the enrollee's functional status, the enrollee's lack of technology or telecommunications infrastructure limits, as determined by the health care provider.

(ii) The telehealth encounter is initiated at the request of the enrollee or authorized by the enrollee before the telehealth encounter.

(b) The use of an audio-only encounter between the enrollee and a health care provider, regardless of whether there is an existing relationship with the health care provider or provider group, if the telehealth encounter is for a behavioral health or substance use disorder service and both items of subdivision (a) of this paragraph apply.

3. Does not include the sole use of a fax machine, instant messages, voice mail or email.

#### **Ariz. Rev. Stat. § 20-1376.05**

##### *Disability Insurance—Telehealth; coverage of health care services; definition*

A. All policies issued, delivered or renewed by a disability insurer in this state must provide coverage for health care services that are provided through telehealth if the health care service would be covered were it provided through an in-person encounter between the insured and a health care provider and provided to an insured receiving the service in this state. The following requirements apply to coverage of telehealth services:

1. Except as otherwise provided in this subsection, a disability insurer may not limit or deny the coverage of health care services provided through telehealth, including ancillary services, and may apply only the same limits or exclusions on a health care service provided through telehealth that are applicable to an in-person encounter for the same health care service, except for procedures or services for which the weight of evidence, based on practice guidelines, peer-reviewed clinical publications or research or recommendations by the telehealth advisory

committee on telehealth best practices established by § 36-3607, determines not to be appropriate to be provided through telehealth.

2. Except as otherwise provided in this paragraph, a disability insurer shall reimburse health care providers at the same level of payment for equivalent services as identified by the healthcare common procedure coding system, whether provided through telehealth using an audio-visual format or in-person care. A disability insurer shall reimburse health care providers at the same level of payment for equivalent in-person behavioral health and substance use disorder services as identified by the healthcare common procedure coding system if provided through telehealth using an audio-only format. This paragraph does not apply to a telehealth encounter provided through a telehealth platform that is sponsored or provided by the disability insurer. A disability insurer may not require a health care provider to use a telehealth platform that is sponsored or provided by the disability insurer as a condition of network participation.

3. Before January 1, 2022, a disability insurer shall cover services provided through an audio-only telehealth encounter if that service is reimbursed by medicare or the Arizona health care cost containment system when provided through an audio-only telehealth encounter. Beginning January 1, 2022, a disability insurer shall cover services provided through an audio-only telehealth encounter if the telehealth advisory committee on telehealth best practices established by § 36-3607 recommends that the services may appropriately be provided through an audio-only telehealth encounter.

4. A health care provider shall bill for a telehealth encounter using the healthcare common procedure coding system and shall identify whether the telehealth encounter was provided in an audio-only or audio-video format. To submit a claim for an audio-only service, the health care provider must make telehealth services generally available to patients through the interactive use of audio, video or other electronic media.

5. At the time of the telehealth encounter, the health care provider shall access clinical information and records, if available, that are appropriate to evaluate the patient's condition. The health care provider shall inform the insured before the telehealth encounter if there is a charge for the encounter.

6. A disability insurer may establish reasonable requirements and parameters for telehealth services,

including documentation, fraud prevention, identity verification and recordkeeping, but such requirements and parameters may not be more restrictive or less favorable to health care providers or insureds than are required for health care services delivered in person.

7. Covered telehealth services may be provided regardless of where the insured is located or the type of site.

8. Except in an emergency as prescribed in § 20-2803, the policy may limit the coverage to those health care providers who are members of the disability insurer's provider network.

B. Subsection A of this section does not:

1. Limit the ability of disability insurers to provide incentives to insureds that are designed to improve health outcomes, increase adherence to a course of treatment or reduce risk.

2. Prevent disability insurers from offering network contracts to health care providers that employ value-based purchasing or bundled payment methodologies if otherwise allowed by law or prevent health care providers from voluntarily agreeing to enter into such contracts with a disability insurer.

C. This section does not relieve a disability insurer from an obligation to provide adequate access to in-person health care services. Network adequacy standards required by federal or state law may not be met by a disability insurer through the use of contracted health care providers who provide only telehealth services and do not provide in-person health care services in this state or within fifty miles of the border of this state.

D. This section does not prevent a disability insurer from imposing deductibles or copayment or coinsurance requirements for a health care service provided through telehealth if the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person encounter for the same health care service. If the disability insurer waives a deductible or copayment or coinsurance requirement that impacts a health care provider's contracted reimbursement rate, the disability insurer shall reimburse the health care provider for the cost of the deductible or copayment or coinsurance requirement to ensure that the health care provider receives the contracted reimbursement rate if the service is covered and the claim meets other requirements of the network participation agreement.

E. Services provided through telehealth or resulting from a telehealth encounter are subject to all of this state's laws and rules that govern prescribing, dispensing and administering prescription pharmaceuticals and devices and shall comply with Arizona licensure requirements and any practice guidelines of the telehealth advisory committee on telehealth best practices established by § 36-3607 or, if not addressed, the practice guidelines of a national association of medical professionals promoting access to medical care for consumers via telecommunications technology or other qualified medical professional societies to ensure quality of care.

F. This section does not apply to limited benefit coverage as defined in § 20-1137.

G. For the purposes of this section, "telehealth":

1. Means the interactive use of audio, video or other electronic media, including asynchronous store-and-forward technologies and remote patient monitoring technologies, for the purpose of diagnosis, consultation or treatment.

2. Includes:

(a) The use of an audio-only telephone encounter between an insured who has an existing relationship with a health care provider or provider group if both of the following apply:

(i) An audio-visual telehealth encounter is not reasonably available due to the insured's functional status, the insured's lack of technology or telecommunications infrastructure limits, as determined by the health care provider.

(ii) The telehealth encounter is initiated at the request of the insured or authorized by the insured before the telehealth encounter.

(b) The use of an audio-only encounter between the insured and a health care provider, regardless of whether there is an existing relationship with the health care provider or provider group, if the telehealth encounter is for a behavioral health or substance use disorder service and both items of subdivision (a) of this paragraph apply.

3. Does not include the sole use of a fax machine, instant messages, voice mail or email.

## ARKANSAS

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No

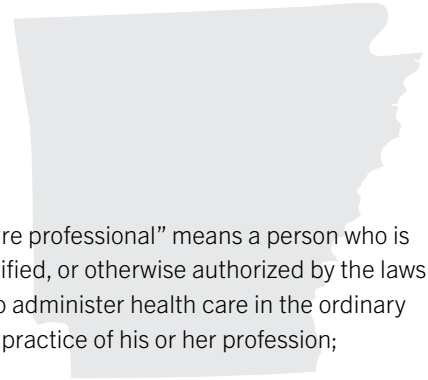


Limited



N/A

# Arkansas



**Authorities: Ark. Code §§ 23-79-1601, 23-79-1602**

## **Ark. Code § 23-79-1601**

### *Definitions*

As used in this subchapter:

(1) “Distant site” means the location of the healthcare professional delivering healthcare services through telemedicine at the time the services are provided;

(2)(A) “Health benefit plan” means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program, and the Arkansas Health and Opportunity for Me Program, or any successor program.

(B) “Health benefit plan” includes:

(i) Indemnity and managed care plans; and

(ii) Nonfederal governmental plans as defined in 29 U.S.C. § 1002(32), as it existed on January 1, 2015.

(C) “Health benefit plan” does not include:

(i) Disability income plans;

(ii) Credit insurance plans;

(iii) Insurance coverage issued as a supplement to liability insurance;

(iv) Medical payments under automobile or homeowners insurance plans;

(v) Health benefit plans provided under Arkansas Constitution, Article 5, § 32, the Workers’ Compensation Law, § 11-9-101 et seq., or the Public Employee Workers’ Compensation Act, § 21-5-601 et seq.;

(vi) Plans that provide only indemnity for hospital confinement;

(vii) Accident-only plans;

(viii) Specified disease plans; or

(ix) Long-term care only plans;

(3) “Healthcare professional” means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of his or her profession;

(4)(A) “Originating site” means a site at which a patient is located at the time healthcare services are provided to him or her by means of telemedicine.

(B) “Originating site” includes the home of a patient;

(5) “Remote patient monitoring” means the use of synchronous or asynchronous 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 professional at a distant site for use in the treatment and management of medical conditions that require frequent monitoring;

(6) “Store-and-forward technology” means the asynchronous transmission of a patient’s medical information from a healthcare professional at an originating site to a healthcare professional at the distant site; and

(7)(A) “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.

(B) “Telemedicine” includes store-and-forward technology and remote patient monitoring.

(C) For the purposes of this subchapter, “telemedicine” does not include the use of:

(i)(a) Audio-only communication, unless the audio-only communication is real-time, interactive, and substantially meets the requirements for a healthcare service that would otherwise be covered by the health benefit plan.

(b) As with other medical services covered by a health benefit plan, documentation of the engagement between patient and provider via audio-only communication shall be placed in the medical record addressing the problem, content of conversation, medical decision-making, and plan

of care after the contact.(c) The documentation described in subdivision

(7)(C)(i)(b) of this section is subject to the same audit and review process required by payers and governmental agencies when requesting documentation of other care delivery such as in-office or face-to-face visits;

(ii) A facsimile machine;

(iii) Text messaging; or

(iv) Email.

### **Ark. Code § 23-79-1602**

#### *Coverage for telemedicine*

(a)(1) This subchapter applies to all health benefit plans delivered, issued for delivery, reissued, or extended in Arkansas on or after January 1, 2016, or at any time when any term of the health benefit plan is changed or any premium adjustment is made thereafter.

(2) Notwithstanding subdivision (a)(1) of this section, this subchapter applies to the Arkansas Medicaid Program on and after January 1, 2016.

(b) A healthcare professional providing a healthcare service provided through telemedicine shall comply with the requirements of the Telemedicine Act, § 17-80-401 et seq.

(c)(1) A health benefit plan shall provide coverage and reimbursement for healthcare services provided through telemedicine on the same basis as the health benefit plan provides coverage and reimbursement for health services provided in person, unless this subchapter specifically provides otherwise.

(2) 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.

(3) A health benefit plan may voluntarily reimburse for healthcare services provided through means described in § 23-79-1601(7)(C).

(d)(1) A health benefit plan shall provide a reasonable facility fee to an originating site operated by a healthcare professional or a licensed healthcare entity if the healthcare professional or licensed healthcare entity is authorized to bill the health benefit plan directly for healthcare services.

(2) 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.

(3) Payment for healthcare services provided through telemedicine shall be provided to the distant site and the originating site upon submission of the appropriate procedure codes.

(4) This section does not:

(A) Prohibit a health benefit plan from paying a facility fee to a provider at the distant site in addition to a fee paid to the healthcare professional; or

(B) Require a health benefit plan to pay more for a healthcare service provided through telemedicine than would have been paid if the healthcare service was delivered in person.

(e) A health benefit plan shall not impose on coverage for healthcare services provided through telemedicine:

(1) An annual or lifetime dollar maximum on coverage for services provided through telemedicine other than an annual or lifetime dollar maximum that applies to the aggregate of all items and services covered;

(2) A deductible, copayment, coinsurance, benefit limitation, or maximum benefit that is not equally imposed upon all healthcare services covered under the health benefit plan; or

(3) A prior authorization requirement for services provided through telemedicine that exceeds the prior authorization requirement for in-person healthcare services under the health benefit plan.

(4) A requirement for a covered person to choose any commercial telemedicine service provider or a restricted network of telemedicine-only providers rather than the covered person's regular doctor or provider of choice; or

(5) A copayment, coinsurance, or deductible that is not equally imposed upon commercial telemedicine providers as those imposed on network providers.

(f) This subchapter does not prohibit a health benefit plan from:

(1) Limiting coverage of healthcare services provided through telemedicine to medically necessary services, subject to the same terms and conditions of the covered person's health benefit plan that apply to services provided in person; or

(2)(A) Undertaking utilization review, including prior

authorization, to determine the appropriateness of healthcare services provided through telemedicine, provided that:

(i) The determination of appropriateness is made in the same manner as determinations are made for the treatment of any illness, condition, or disorder covered by the health benefit plan whether the service was provided in-person or through telemedicine; and

(ii) All adverse determinations for healthcare services, medications, or equipment prescribed by a physician are made by a physician who possesses a current and valid unrestricted license to practice medicine in Arkansas.

(B) Utilization review shall not require prior authorization of emergent telemedicine services.

(g)(1) A health benefit plan may adopt policies to ensure that healthcare services provided through

telemedicine submitted for payment comply with the same coding, documentation, and other requirements necessary for payment as an in-person service other than the in-person requirement.

(2) If deemed necessary, the State Insurance Department may promulgate rules containing additional standards and procedures for the utilization of telemedicine to provide healthcare services through health benefit plans if the additional standards and procedures do not conflict with this subchapter or § 17-80-117 and are applied uniformly by all health benefit plans.

(h) A health benefit plan shall not prohibit a healthcare professional from charging a patient enrolled in a health benefit plan for healthcare services provided by audio-only communication that are not reimbursed under the health benefit plan.



# CALIFORNIA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A



# California

**Authorities: Cal. Health & Safety Code §§ 1374.13, 1374.14; Cal. Ins. Code §§ 10123.85, 10123.855; Cal. Bus. & Prof. Code § 2290.5**

## **Cal. Health & Safety Code §1374.13**

*Telehealth; medical services without in-person contact; type of setting where services are provided; health care service plan and Medi-Cal managed care plan contracts with the department; use of telehealth not to be required if inappropriate*

(a) For the purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the health care provider.

(c) A health care service plan shall not require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups, and pursuant to Section 1374.14.

(d) A health care service plan shall not limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups, and pursuant to Section 1374.14.

(e) This section shall also apply to health care service plan contracts and Medi-Cal managed care plan contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(f) Notwithstanding any other law, this section does not authorize a health care service plan to require the use of telehealth if the health care provider has determined that it is not appropriate.

## **Cal. Health & Safety Code § 1374.14**

*Telehealth services; requirements for health care service plan contracts*

(a) (1) A contract between a health care service plan and a health care provider for the provision of health care services to an enrollee or subscriber shall specify that the health care service plan shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an enrollee or subscriber appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health care service plan and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health care service plan and the provider shall ensure the rate is consistent with subdivision (h) of Section 1367.

(3) This section does not require telehealth reimbursement to be unbundled from other capitated or bundled, risk-based payments.

(b) (1) A health care service plan contract shall specify that the health care service plan shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for coverage for the same service through in-person diagnosis, consultation,

or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers. of care after the contact.

(2) This section does not alter the obligation of a health care service plan to ensure that enrollees have access to all covered services through an adequate network of contracted providers, as required under Sections 1367, 1367.03, and 1367.035, and the regulations promulgated thereunder.

(3) This section does not require a health care service plan to cover telehealth services provided by an out-of-network provider, unless coverage is required under other law.

(c) A health care service plan may offer a contract containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

(f) This section shall not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

#### **Cal. Ins. Code § 10123.85**

*Telehealth; medical services without in-person contact; type of setting where services are provided; health care service plan contracts with department; use of telehealth not to be required if inappropriate*

(a) For purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the health care provider.

(c) A health insurer shall not require that in-person contact occur between a health care provider and a patient before payment is made for the services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the policyholder or contractholder and the insurer, and between the insurer and its participating providers or provider groups, and pursuant to Section 10123.855.

(d) A health insurer shall not limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided by telehealth, subject to the terms and conditions of the contract between the policyholder or contractholder and the insurer, and between the insurer and its participating providers or provider groups, and pursuant to Section 10123.855.

(e) Notwithstanding any other law, this section does not authorize a health insurer to require the use of telehealth if the health care provider has determined that it is not appropriate.

#### **Cal. Ins. Code § 10123.855**

*Telehealth services; requirements for health insurance contracts*

(a) (1) A contract, between a health insurer and a health care provider for an alternative rate of payment pursuant to Section 10133 shall specify that the health insurer shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an insured or policyholder appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health insurer and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services

that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health insurer and the provider shall ensure the rate is consistent with subdivision (a) of Section 10123.137.

(b) (1) A policy of health insurance issued, that provides benefits through contracts with providers at alternative rates of payment shall specify that the health insurer shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

(2) This section does not alter the existing statutory or regulatory obligations of a health insurer to ensure that insureds have access to all covered services through an adequate network of contracted providers, as required by Sections 10133 and 10133.5 and the regulations promulgated thereunder.

(3) This section does not require a health insurer to deliver health care services through telehealth services.

(4) This section does not require a health insurer to cover telehealth services provided by an out-of-network provider, unless coverage is required under other provisions of law.

(c) A health insurer may offer a policy containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

(f) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

Cal. Bus. & Prof. Code § 2290.5

Telehealth; definitions; consent; in-person health care delivery services; violations; scope of practice; confidentiality; exceptions; privileges and credentials of telehealth service providers

(a) For purposes of this division, the following definitions apply:

(1) "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site.

(2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means any of the following:

(A) A person who is licensed under this division.

(B) A marriage and family therapist intern or trainee functioning pursuant to Section 4980.43.

(C) A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 1374.73 of the Health and Safety Code and Section 10144.51 of the Insurance Code.

(D) An associate clinical social worker functioning pursuant to Section 4996.23.2.

(E) An associate professional clinical counselor or clinical counselor trainee functioning pursuant to Section 4999.46.3.

(4) "Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) "Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

(6) "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. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Before 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.

(c) This section does not 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.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section does not alter the scope of practice of a health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient's rights to the patient's medical information shall apply to telehealth interactions.

(g) All laws and regulations governing professional responsibility, unprofessional conduct, and standards of practice that apply to a health care provider under the health care provider's license shall apply to that health care provider while providing telehealth services.

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

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

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

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

# COLORADO

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A



# Colorado

**Authority: Colo. Rev. Stat. § 10-16-123**

## Colo. Rev. Stat. § 10-16-123

### *Telehealth—definitions*

(1) It is the intent of the general assembly to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a provider without in-person contact with the provider.

(2)(a) On or after January 1, 2017, a health benefit plan that is issued, amended, or renewed in this state shall not require in-person contact between a provider and a covered person for services appropriately provided through telehealth, subject to all terms and conditions of the health benefit plan. Nothing in this section requires the use of telehealth when a provider determines that delivery of care through telehealth is not appropriate or when a covered person chooses not to receive care through telehealth. A provider is not obligated to document or demonstrate that a barrier to in-person care exists to trigger coverage under a health benefit plan for services provided through telehealth.

(b)(I) Subject to all terms and conditions of the health benefit plan, a carrier shall reimburse the treating participating provider or the consulting participating provider for the diagnosis, consultation, or treatment of the covered person delivered through telehealth on the same basis that the carrier is responsible for reimbursing that provider for the provision of the same service through in-person consultation or contact by that provider.

(II) A carrier shall not restrict or deny coverage of a health care service that is a covered benefit solely:

(A) Because the service is provided through telehealth rather than in-person consultation or contact between the participating provider or, subject to section 10-16-704, the nonparticipating provider and the covered person where the health care service is appropriately provided through telehealth; or

(B) Based on the communication technology or application used to deliver the telehealth services pursuant to this section.

(III) Section 10-16-704 applies to this subsection (2)(b), and the availability of telehealth services does not modify the requirements imposed on carriers under that section to provide a sufficient network of providers available in the community to provide in-person health care services.

(c) 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 that, for purposes of this subsection (2)(c), the carrier is not required to pay or reimburse for any transmission costs the covered person incurred or originating site fees, regardless of how or by whom the fees are billed, for the delivery of health care services through telehealth to or from the covered person's home or a private residence.

(d) A carrier may offer a health coverage plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telehealth, but the deductible, copayment, or coinsurance amount must not exceed the deductible, copayment, or coinsurance applicable if the same health care services are provided through in-person diagnosis, consultation, or treatment.

(e) A carrier shall not:

(I) Impose an annual dollar maximum on coverage for health care services covered under the health benefit plan that are delivered through telehealth, other than an annual dollar maximum that applies to the same services when performed by the same provider through in-person care;

(II) Impose specific requirements or limitations on the HIPAA-compliant technologies that a provider uses to deliver telehealth services, including limitations on audio or live video technologies;

(III) Require a covered person to have a previously established patient-provider relationship with a specific provider in order for the covered person to receive medically necessary telehealth services from the provider; or

(IV) Impose additional certification, location, or training requirements on a provider as a condition of reimbursing the provider for providing health care services through telehealth.

(f) If a covered person receives health care services through telehealth, a carrier shall apply the applicable copayment, coinsurance, or deductible amount to the telehealth services under the health benefit plan, which copayment, coinsurance, or deductible amount shall not exceed the amounts applicable to those health care services when performed by the same provider through in-person care.







(g)(I) Repealed by Laws 2021, Ch. 113 (S.B. 21-139), § 1, eff. May 7, 2021.

(II) This section does not apply to:

(A) Short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts; or

(B) Policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the “Social Security Act”, as amended, or any other similar coverage under state or federal governmental plans.

(h) Nothing in this section prohibits a carrier from providing coverage or reimbursement for health care services appropriately provided through telehealth to a covered person who is not located at an originating site.

(3) A health benefit plan or dental 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.

(4) As used in this section:

(a) “Distant site” means a site at which a provider is located while providing health care services by means of telehealth.

(b) “Originating site” means a site at which a patient is located at the time health care services are provided to him or her by means of telehealth.

(b.5) “Remote monitoring” means the use of synchronous or asynchronous technologies to collect or monitor medical and other forms of health data for individuals at an originating site and electronically transmit that information to providers at a distant site so providers can assess, diagnose, consult, treat, educate, provide care management, suggest self-management, or make recommendations regarding a covered person’s health care.

(c) “Store-and-forward transfer” means the electronic transfer of a patient’s medical information or an interaction between providers that occurs between an originating site and distant sites when the patient is not present.

(d) Repealed by Laws 2020, Ch. 235 (S.B. 20-212), § 2, eff. July 6, 2020.

(e) “Telehealth” means a mode of delivery of health care services through HIPAA-compliant telecommunications systems, including information, electronic, and communication technologies, remote monitoring technologies, and store-and-forward transfers, 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.

## CONNECTICUT

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Connecticut

**Authorities:** Conn. Gen. Stat. §§§§ 38a-499a, 38a-526a, 19a-906, 19a-906a

## Conn. Gen. Stat. § 38a-499a<sup>2</sup>

*Individual Health Insurance—Coverage for telehealth services*

(a) As used in this section, “telehealth” has the same meaning as provided in section 19a-906, as amended by this act.

(b) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for medical advice, diagnosis, care or treatment provided through telehealth, to the extent coverage is provided for such advice, diagnosis, care or treatment when provided through in-person consultation between the insured and a health care provider licensed in the state. Such coverage shall be subject to the same terms and conditions applicable to all other benefits under such policy.

(c) No such policy shall: (1) Exclude a service for coverage solely because such service is provided only through telehealth and not through in-person consultation between the insured and a health care provider licensed in the state, provided telehealth is appropriate for the provision of such service; or (2) be required to reimburse a treating or consulting health care provider for the technical fees or technical costs for the provision of telehealth services.

(d) Nothing in this section shall prohibit or limit a health insurer, health care center, hospital service corporation, medical service corporation or other entity from conducting utilization review for telehealth services, provided such utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service.

## Conn. Gen. Stat. § 38a-526a<sup>3</sup>

*Group Health Insurance—Coverage for telehealth services*

(a) As used in this section, “telehealth” has the same meaning as provided in section 19a-906, as amended by this act.

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for medical advice, diagnosis, care or treatment provided through telehealth, to the extent coverage is provided for such advice, diagnosis, care or treatment when provided through in-person consultation between the insured and a health care provider licensed in the state. Such coverage shall be subject to the same terms and conditions applicable to all other benefits under such policy.

(c) No such policy shall: (1) Exclude a service for coverage solely because such service is provided only through telehealth and not through in-person consultation between the insured and a health care provider, provided telehealth is appropriate for the provision of such service; or (2) be required to reimburse a treating or consulting health care provider licensed in the state for the technical fees or technical costs for the provision of telehealth services.

(d) Nothing in this section shall prohibit or limit a health insurer, health care center, hospital service corporation, medical service corporation or other entity from conducting utilization review for telehealth services, provided such utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service.

## Conn. Gen. Stat. § 19a-906

*Telehealth Services*

(a) As used in this section:

(1) “Asynchronous” means any transmission to another site for review at a later time that uses a camera or other technology to capture images or data to be recorded.

<sup>2</sup>Note: This report includes the statutory language effective July 1, 2024.

<sup>3</sup>Note: This report includes the statutory language effective July 1, 2024.

(2) “Facility fee” has the same meaning as in section 19a-508c.

(3) “Health record” means the record of individual, health-related information that may include, but need not be limited to, continuity of care documents, discharge summaries and other information or data relating to a patient’s demographics, medical history, medication, allergies, immunizations, laboratory test results, radiology or other diagnostic images, vital signs and statistics.

(4) “Medical history” means information, including, but not limited to, a patient’s past illnesses, medications, hospitalizations, family history of illness if known, the name and address of the patient’s primary care provider if known and other matters relating to the health condition of the patient at the time of a telehealth interaction.

(5) “Medication-assisted treatment” means the use of medications approved by the federal Food and Drug Administration, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.

(6) “Originating site” means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth.

(7) “Peripheral devices” means the instruments a telehealth provider uses to perform a patient exam, including, but not limited to, stethoscope, otoscope, ophthalmoscope, sphygmomanometer, thermometer, tongue depressor and reflex hammer.

(8) “Remote patient monitoring” means the personal health and medical data collection from a patient in one location via electronic communication technologies that is then transmitted to a telehealth provider located at a distant site for the purpose of health care monitoring to assist the effective management of the patient’s treatment, care and related support.

(9) “Store and forward transfer” means the asynchronous transmission of a patient’s medical information from an originating site to the telehealth provider at a distant site.

(10) “Synchronous” means real-time interactive technology.

(11) “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.

(12) “Telehealth provider” means any physician licensed under chapter 370, physical therapist licensed under chapter 376, chiropractor licensed under chapter 372, naturopath licensed under chapter 373, podiatrist licensed under chapter 375, occupational therapist licensed under chapter 376a, optometrist licensed under chapter 380, registered nurse or advanced practice registered nurse licensed under chapter 378, physician assistant licensed under chapter 370, psychologist licensed under chapter 383, marital and family therapist licensed under chapter 383a, clinical social worker or master social worker licensed under chapter 383b, alcohol and drug counselor licensed under chapter 376b, professional counselor licensed under chapter 383c, dietitian-nutritionist certified under chapter 384b, speech and language pathologist licensed under chapter 399, respiratory care practitioner licensed under chapter 381a, audiologist licensed under chapter 397a, pharmacist licensed under chapter 400j, or paramedic licensed pursuant to chapter 384d who is providing health care or other health services through the use of telehealth within such person’s scope of practice and in accordance with the standard of care applicable to the profession.

(b) (1) A telehealth provider shall only provide telehealth services to a patient when the telehealth provider: (A) Is communicating through real-time, interactive, two-way communication technology or store and forward technologies; (B) has access to, or knowledge of, the patient’s medical history, as provided by the patient, and the patient’s health record, including the name and address of the patient’s primary care provider, if any; (C) conforms to the standard of care applicable to the telehealth provider’s profession and expected for in-person care as appropriate to the patient’s age and presenting condition, except when the standard of care requires the use of diagnostic testing and performance of a physical examination, such testing or examination may be carried out through the use of peripheral devices appropriate to the patient’s condition; and (D) provides the patient with the telehealth’s provider license number and contact information.

(2) At the time of the telehealth provider's first telehealth interaction with a patient, the telehealth provider shall inform the patient concerning the treatment methods and limitations of treatment using a telehealth platform and, after providing the patient with such information, obtain the patient's consent to provide telehealth services. The telehealth provider shall document such notice and consent in the patient's health record. If a patient later revokes such consent, the telehealth provider shall document the revocation in the patient's health record.

(c) Notwithstanding the provisions of this section or title 20, 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, as defined in section 20-14o, in a manner fully consistent with the Ryan Haight Online Pharmacy Consumer Protection Act, 21 USC 829(e), as amended from time to time, for the treatment of a person with a psychiatric disability or substance use disorder, as defined in section 17a-458, including, but not limited to, medication-assisted treatment. A telehealth provider using telehealth to prescribe a schedule II or III controlled substance pursuant to this subsection shall electronically submit the prescription pursuant to section 21a-249.

(d) Each telehealth provider shall, at the time of the initial telehealth interaction, ask the patient whether the patient consents to the telehealth provider's disclosure of records concerning the telehealth interaction to the patient's primary care provider. If the patient consents to such disclosure, the telehealth provider shall provide records of all telehealth interactions to the patient's primary care provider, in a timely manner, in accordance with the provisions of sections 20-7b to 20-7e, inclusive.

(e) Any consent required under this section shall be obtained from the patient, or the patient's legal guardian, conservator or other authorized representative, as applicable.

(f) The provision of telehealth services and health records maintained and disclosed as part of a telehealth interaction shall comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 19 P.L. 104-191, as amended from time to time.

(g) Nothing in this section shall prohibit: (1) A health care provider from providing on-call coverage pursuant to an agreement with another health care

provider or such health care provider's professional entity or employer; (2) a health care provider from consulting with another health care provider concerning a patient's care; (3) orders of health care providers for hospital outpatients or inpatients; or (4) the use of telehealth for a hospital inpatient, including for the purpose of ordering any medication or treatment for such patient in accordance with Ryan Haight Online Pharmacy Consumer Protection Act, 21 USC 829(e), as amended from time to time.

For purposes of this subsection, "health care provider" means a person or entity licensed or certified pursuant to chapter 370, 372, 373, 375, 376 to 376b, 20 inclusive, 378, 379, 21 380, 381a, 383 to 383c, inclusive, 384b, 397a, 399 or 400j, or licensed or certified pursuant to chapter 368d22 or 384d.23

(h) No telehealth provider or hospital shall charge a facility fee for telehealth services. Such prohibition shall apply to hospital telehealth services whether provided on campus or otherwise. For purposes of this subsection, "hospital" has the same meaning as provided in section 19a-490 and "campus" has the same meaning as provided in section 19a-508c.

#### **Conn. Gen. Stat. § 19a-906a**

*Issuance of order authorizing out-of-state telehealth providers to provide telehealth services to patients in this state.*

The Commissioner of Public Health may issue an order authorizing telehealth providers who are not licensed, certified or registered to practice in this state to provide telehealth services to patients in this state. Such order may be of limited duration and limited to one or more types of providers described in subdivision (13) of subsection (a) of section 1 of public act 21-9, 1 or subdivision (12) of subsection (a) of section 19a-906. The commissioner may impose conditions including, but not limited to, a requirement that any telehealth provider providing telehealth services to patients in this state pursuant to such order shall submit an application for licensure, certification or registration, as applicable. The commissioner may suspend or revoke any authorization provided pursuant to this section to a telehealth provider who violates any condition imposed by the commissioner or applicable requirements for the provision of telehealth services under the law. Any such order issued pursuant to this section shall not constitute a regulation, as defined in section 4-166.

## DELAWARE

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A

# Delaware

**Authorities: 18 Del. Code §§ 3370, 3571R; 18 Del. Admin. Code 1409-2.0, -3.0, -4.0**

## 18 Del. Code § 3370

*Health Insurance Contracts—Telehealth and telemedicine*

(a) For purposes of this section:

(1) “Distant site” means a site at which a health-care provider legally allowed to practice in Delaware is located while providing health-care services by means of telemedicine or telehealth.

(2) “Originating site” means a site in Delaware at which a patient is located at the time health-care services are provided to the patient by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used. Notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(3) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(4) “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 authorized in Chapter 60 of Title 24.

(5) “Telemedicine” is a subset of telehealth which is the delivery of clinical health-care services and other services, as authorized in Chapter 60 of Title 24, by means of real time 2-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 health-care 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 legally allowed to practice in Delaware and practicing

within the health-care provider’s scope of practice as would be practiced in-person with a patient, while such patient is at an originating site and the health-care provider is at a distant site.

(b) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each health service corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine.

(c) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each health service corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telehealth as directed through regulations promulgated by the Department.

(d) An insurer, health service corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

(e) An insurer, health service corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation or treatment of the insured delivered through telemedicine services on the same basis and at least at the rate that the insurer, health service corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact. Payment for telemedicine interactions shall include reasonable compensation to the originating or

distant site for the transmission cost incurred during the delivery of health care services.

(f) No insurer, health service corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract or plan.

(g) The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on and after January 1, 2016, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

(h) This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor shall it contravene any telehealth requirements made in policies or contracts designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act [42 U.S.C. §§ 1395 et seq., 1396 et seq., and 1397aa et seq.], known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

### **18 Del. Code § 3571R**

#### *Group and Blanket Health Insurance—Telehealth and telemedicine*

(a) For purposes of this section:

(1) “Distant site” means a site at which a health-care provider legally allowed to practice in Delaware is located while providing health-care services by means of telemedicine or telehealth.

(2) “Originating site” means a site in Delaware at which a patient is located at the time health-care services are provided to the patient by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used. Notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(3) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(4) “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 authorized in Chapter 60 of Title 24.

(5) “Telemedicine” means a form of telehealth which is the delivery of clinical health-care services, and other services, as authorized in Chapter 60 of Title 24, by means of real time 2-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 health-care 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 legally allowed to practice in Delaware and practicing within the health-care provider’s scope of practice as would be practiced in-person with a patient, while such patient is at an originating site and the health-care provider is at a distant site.

(b) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine.

(c) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health-care plan for health-care services shall provide coverage for the cost of such health-care services provided through telehealth as directed through regulations promulgated by the Department.



(d) An insurer, health service corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health-care provider and a patient for services appropriately provided through telemedicine services.

(e) An insurer, health service corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis and at least at the rate that the insurer, health service corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact. Payment for telemedicine interactions shall include reasonable compensation to the originating or distant site for the transmission cost incurred during the delivery of health-care services.

(f) No insurer, health service corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(g) The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on and after January 1, 2016, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

(h) This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor shall it contravene any telehealth requirements made in policies or contracts designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act [42 U.S.C. §§ 1395 et seq., 1396 et seq., and 1397aa et seq.], known as Medicare and Medicaid, or any other similar coverage under state or federal governmental plans.

## 18 Del. Admin. Code 1409-2.0

### *Definitions*

The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly indicates otherwise:

“Distant site” means a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telehealth.

“Originating site” means a site in Delaware at which a patient is located at the time health care services are provided to the patient by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used.

Notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

“Store and forward transfer” means the synchronous or asynchronous transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time, as set forth in 24 Del.C. § 6001(4).

“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, health-care provider consultation, patient and professional health-related education, public health, health administration, and other services as authorized in 24 Del.C. Ch. 60.

“Telemedicine” is a subset of telehealth which is the delivery of clinical health-care services and other services, as authorized in 24 Del.C. Ch. 60, by means of real time 2-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 health-care 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 legally allowed to practice in the state and practicing within the health-care provider’s scope of practice as would be practiced in-person with a patient, while such patient is at an originating site and the health-care provider is at a distant site.





### **18 Del. Admin. Code 1409-3.0**

#### *Compliance with Statutes Regarding Telemedicine and Telehealth*

Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each health service corporation providing individual or group accident and sickness subscription contracts; and each managed care organization and health maintenance organization providing a health care plan for health care services shall comply with the provisions of 18 Del.C. §§ 3370 and 3571R, and this regulation.

### **18 Del. Admin. Code 1409-4.0**

#### *Telehealth*

4.1 Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each health service corporation providing individual or group accident and sickness subscription contracts; and each managed care organization and health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telehealth. Coverage for health care services provided through telehealth shall be provided so long as the underlying health care service is a covered service and the health care provider providing the service is licensed to furnish the service under State law and is practicing within the scope of State law, including but not limited to 24 Del.C. Ch. 60.

4.2 No insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; health service corporation providing individual or group accident and sickness subscription contracts; or managed care organization or health maintenance organization providing a health care plan for health care services shall impose any limitation on the ability of an insured to seek medical care through the use of telehealth service solely because the health care service is being provided through telehealth. Such prohibited limitations shall include, but not be limited to, preauthorization, medical necessity, homebound requirements, or requiring the use of technology permitting visual communication.

## DISTRICT OF COLUMBIA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A

# District of Columbia

**Authorities: D.C. Code §§ 31-3861, 31-3862**

## **D.C. Code § 31-3861**

### *Definitions*

For the purposes of this chapter, the term:

- (1) “Health benefits plan” shall have the same meaning as provided in § 31-3131(4).
- (2) “Health insurer” shall have the same meaning as provided in § 31-3131(5).
- (2A) “Postpartum” means the time after delivery when maternal physiological changes related to pregnancy return to the nonpregnant state, which may last for as long as 12 months after delivery.
- (3) “Provider” shall have the same meaning as provided in § 31-3131(7).
- (4) “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 email messages, or facsimile transmissions are not included.

## **D.C. Code § 31-3862**

### *Private reimbursement*

(a) A health insurer offering a health benefits plan in the District may not deny coverage for a healthcare service on the basis that the service is provided through telehealth if the same service would be covered when delivered in person.

(b) A health insurer shall reimburse the provider for the diagnosis, consultation, or treatment of the insured when the service is delivered through telehealth.

(c) A health insurer shall not be required to:

- (1) Reimburse a provider for health care service delivered through telehealth that is not a covered under the health benefits plan; and
- (2) Reimburse a provider who is not a covered provider under the health benefits plan.

(d) A health insurer may require a deductible, copayment or coinsurance amount for a health care service delivered through telehealth; provided, that the deductible, copayment or coinsurance amount may not exceed the amount applicable to the same service when it is delivered in person.

(e) A health insurer shall not impose any annual or lifetime dollar maximum on coverage for telehealth services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services under the health benefits plan.

(f) Nothing in this chapter shall preclude the health insurer from undertaking utilization review to determine the appropriateness of telehealth as a means of delivering a health care service; provided, that the determinations shall be made in the same manner as those regarding the same service when it is delivered in person.





## FLORIDA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No

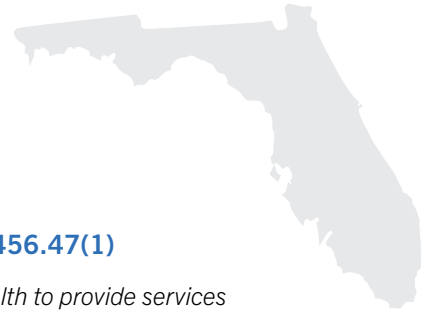


Limited



N/A

# Florida



**Authorities: Fla. Stat. §§ 627.42396, 641.31(45), 456.47(1)**

## **Fla. Stat. § 627.42396<sup>4</sup>**

### *Reimbursement for telehealth services*

A contract between a health insurer issuing major medical comprehensive coverage through an individual or group policy and a telehealth provider, as defined in s. 456.47, must be voluntary between the insurer and the provider and must establish mutually acceptable payment rates or payment methodologies for services provided through telehealth. Any contract provision that distinguishes between payment rates or payment methodologies for services provided through telehealth and the same services provided without the use of telehealth must be initialed by the telehealth provider.

## **Fla. Stat. § 641.31(45)**

### *Health maintenance contracts*

A contract between a health maintenance organization issuing major medical individual or group coverage and a telehealth provider, as defined in s. 456.47, must be voluntary between the health maintenance organization and the provider and must establish mutually acceptable payment rates or payment methodologies for services provided through telehealth. Any contract provision that distinguishes between payment rates or payment methodologies for services provided through telehealth and the same services provided without the use of telehealth must be initialed by the telehealth provider.

## **Fla. Stat. § 456.47(1)**

### *Use of telehealth to provide services*

(1) Definitions.--As used in this section, the term:

(a) “Telehealth” means the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include e-mail messages or facsimile transmissions.

(b) “Telehealth provider” means any individual who provides health care and related services using telehealth and who is licensed or certified under s. 393.17; part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I, part II, or part III of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; who is licensed under a multistate health care licensure compact of which Florida is a member state; or who is registered under and complies with subsection (4).

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<sup>4</sup>Florida’s telehealth commercial payer law does not mandate a health plan to cover services delivered via telehealth. The language merely clarifies that contracts signed by insurers with telehealth providers must be “voluntary” with mutually acceptable rates or payment methodologies and requires the telehealth provider to initial any contract provision that would cause telehealth reimbursement to be different than reimbursement for the same services provided in-person. See Fla. Stat. § 627.42396; see also Fla. Stat. § 641.31(45) (same for health maintenance contracts).

## GEORGIA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A



# Georgia

**Authority: Ga. Code § 33-24-56.4**

## **Ga. Code § 33-24-56.4**

### *Georgia Telehealth Act*

(a) This Code section shall be known and may be cited as the “Georgia Telehealth Act.”

(b) As used in this Code section, the term:

(1) ‘Distant site’ means a site at which a health care provider legally allowed to practice in this state is located while providing health care services by means of telemedicine or telehealth, which may include the home of the health care provider.

(2) ‘Health benefit policy’ means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed in this state, including, but not limited to, any health insurance plan established under Article 1 of Chapter 18 of Title 45 or under Article 7 of Chapter 4 of Title 49.

(3) ‘Insurer’ means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, managed care entity, or any similar entity authorized to issue contracts under this title or to provide health benefit policies.

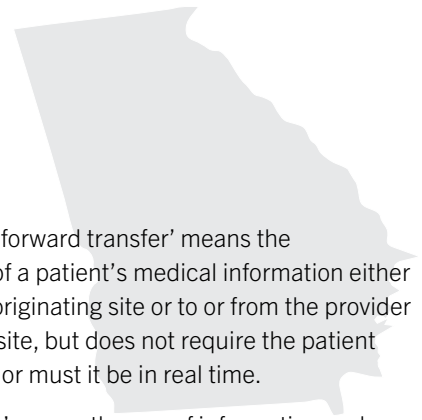
(3.1) “Interprofessional consultation” means an assessment and management service in which a patient’s health care provider seeks treatment advice from a consulting provider with specific specialty expertise to assist the patient’s health care provider in diagnosing or treating the patient.

(4) ‘Originating site’ means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, which may include a patient’s home, workplace, or school; provided, however, that notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(5) ‘Store and forward transfer’ means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present or must it be in real time.

(6) ‘Telehealth’ means the use of information and communications technologies, including, but not limited to, telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health related education, public health, and health administration.

(7) ‘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 health care 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 as prescribed by applicable federal and state laws, rules, and regulations, and legally allowed to practice in this state, while such patient is at an originating site and the health care provider is at a distant site. Such term includes audio-only telephone only when no other means of real-time two-way audio, visual, or other telecommunications or electronic communications, due to lack of adequate broadband access, or because the use of other means of real-time two-way audio, visual, or other telecommunications or electronic communications is infeasible, impractical, or otherwise not medically advisable, as determined by the health care provider providing telemedicine services to the patient or as determined by another health care provider with an existing relationship with the patient.



(c) It is the intent of the General Assembly to mitigate geographic discrimination in the delivery of health care by recognizing the application of and payment for covered medical care provided by means of telehealth, provided that such services are provided by a physician or by another health care practitioner or professional acting within the scope of practice of such health care practitioner or professional and in accordance with the provisions of Code Section 43-34-31.

(d) Each insurer proposing to issue a health benefit policy shall provide coverage for the cost of health care services provided through telehealth or telemedicine as directed through regulations promulgated by the department.

(e) An insurer shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

(f) No insurer shall require an in-person consultation or contact before a patient may receive telemedicine services from a health care provider, except for the purposes of initial installation, setup, or delivery of in-home telehealth devices or services, or as otherwise required by state or federal law, rule, or regulation.

(g) An insurer shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis and at least at the rate that the insurer is responsible for coverage for the provision of the same service through in-person consultation or contact; provided, however, that nothing in this subsection shall require (1) a health care provider or telemedicine company to accept more reimbursement than they are willing to charge or (2) an insurer to pay for a telemedicine service provided through an audio-only call for any services other than mental or behavioral health services. Payment for telemedicine interactions shall include reasonable compensation to the originating or distant site for the transmission cost incurred during the delivery of health care services; provided, however, that this shall not require the insurer to include payment for transmission costs if the originating site is a home.

(h) If a treating provider obtains interprofessional consultation from a consulting provider for a patient for whom the treating provider conducted an examination through telemedicine services, an insurer shall not require the consulting provider to conduct, either in-person or through telemedicine services, an examination of such patient in order to receive reimbursement, unless such examination by the consulting provider would be required for the provision of the same services when the initial examination of the patient by the treating provider was conducted through in-person consultation or contact.

(i) No insurer shall impose any deductible or annual or lifetime dollar maximum on coverage for telemedicine services other than a deductible or annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this Code section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the health benefit policy.

(j) No insurer shall require its insureds to use telemedicine services in lieu of in-person consultation or contact.

(k) On and after January 1, 2020, every health benefit policy that is issued, amended, or renewed shall include payment for services that are covered under such health benefit policy and are appropriately provided through telehealth in accordance with Code Section 43-34-31 [Georgia's Medical Practice Act], this Code section, and generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided.

(l) No insurer shall impose any type of utilization review on telemedicine services unless such type of utilization review is imposed when the same services are provided through in-person consultation or contact.

(m) No insurer shall restrict coverage of telehealth or telemedicine services to services provided by a particular vendor, or other third party, or services provided through a particular electronic communications technology platform; provided,

however, that nothing in this Code section shall require an insurer to cover any telehealth or telemedicine services provided through an electronic communications technology platform that does not comply with applicable state and federal privacy laws.

(n) No insurer shall place any restrictions on prescribing medications through telemedicine that are more restrictive than what is required under applicable state and federal laws for prescribing medications through in-person consultation or contact.

(o) A health care provider shall maintain documentation of each health care service provided

through telemedicine in a manner that is at least as extensive and thorough as when the health care service is provided through in-person consultation or contact and, upon request, make such documentation available in accordance with applicable state and federal law.

(p) Nothing in this Code section shall be construed to limit, alter, or expand the scope of practice, standard of care, prescriptive authority, or supervision requirements for health care providers or privacy rights, other than as provided in applicable federal law and state laws, rules, and regulations.



## HAWAII

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No

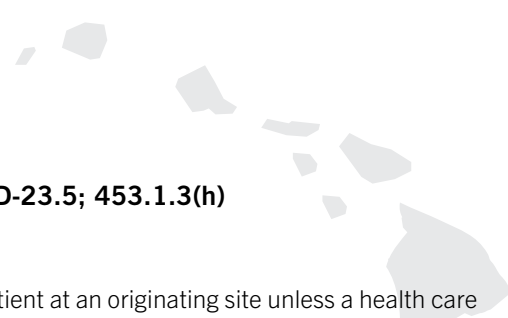


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N/A

# Hawaii



**Authorities:** Haw. Rev. Stat. §§ 431:10A-116.3; 432D-23.5; 453.1.3(h)

## **Haw. Rev. Stat. § 431:10A-116.3**

*Accident and Health or Sickness Insurance  
Contracts—Coverage for telehealth*

(a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without in-person contact with the health care provider.

(b) No accident and health or sickness insurance plan that is issued, amended or renewed shall require in-person contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the insurer, and the health care provider.

(c) Reimbursement for services provided through telehealth via an interactive telecommunications system shall be equivalent to reimbursement for the same services provided via in-person contact between a health care provider and a patient; Provided that reimbursement for two-way, real-time audio-only communication technology for purposes of diagnosis, evaluation, or treatment of a mental health disorder to a patient in the patient's home shall be equivalent to eighty per cent of the reimbursement for the same services provided via in-person contact between a health care provider and a patient. To be reimbursed for telehealth via an interactive telecommunications system using two-way, real-time audio-only communication technology in accordance with this subsection, the health care provider shall first conduct an in-person visit or a telehealth visit that is not audio only, within six months prior to the initial audio-only visit, or within twelve months prior to any subsequent audio-only visit. The telehealth visit required prior to the initial or subsequent audio-only visit in this subsection shall not be provided using audio-only communication. Nothing in this section shall require a health care provider to be physically present with the

patient at an originating site unless a health care provider at the distant site deems it necessary.

(d) Notwithstanding chapter 453 or rules adopted pursuant thereto, in the event that a health care provider-patient relationship does not exist between the patient and the health care provider to be involved in a telehealth interaction between the patient and the health care provider, a telehealth mechanism may be used to establish a health care provider-patient relationship.

(e) All insurers shall provide current and prospective insureds with written disclosure of coverages and benefits associated with telehealth services, including information on copayments, deductibles, or coinsurance requirements under a policy, contract, plan, or agreement. The information provided shall be current, understandable, and available prior to the issuance of a policy, contract, plan, or agreement, and upon request after the policy, contract, plan, or agreement has been issued.

(f) Services provided by telehealth pursuant to this section shall be consistent with all federal and state privacy, security and confidentiality laws.

(g) For the purposes of this section:

“Distant site” means the location of the health care provider delivering services through telehealth at the time the services are provided.

“Health care provider” means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

“Interactive telecommunications system” has the same meaning as the term is defined in title 42 Code of Federal Regulations section 410.78(a).

“Originating site” means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider’s office, hospital, health care facility, a patient’s home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

“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. Except as provided through an interactive telecommunications system, standard telephone contacts, facsimile transmissions or e-mail text, in combination or alone, do not constitute a telehealth service for the purposes of this chapter.

#### **Haw. Rev. Stat. § 432D-23.5**

##### *Health Maintenance Organization Act—Coverage for telehealth*

(a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without in-person contact with the health care provider.

(b) No health maintenance organization plan that is issued, amended, or renewed shall require in-person contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may

be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the health maintenance organization, and the health care provider.

(c) Reimbursement for services provided through telehealth via an interactive telecommunications system shall be equivalent to reimbursement for the same services provided via in-person contact between a health care provider and a patient; provided that reimbursement for two-way, real-time audio-only communication technology for purposes of diagnosis, evaluation, or treatment of a mental health disorder to a patient in the patient’s home shall be equivalent to eighty per cent of the reimbursement for the same services provided via in-person contact between a health care provider and a patient.

To be reimbursed for telehealth via an interactive telecommunications system using two-way, real-time audio-only communication technology in accordance with this subsection, the health care provider shall first conduct an in-person visit or a telehealth visit that is not audio only, within six months prior to the initial audio-only visit, or within twelve months prior to any subsequent audio-only visit. The telehealth visit required prior to the initial or subsequent audio-only visit in this subsection shall not be provided using audio-only communication. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

(d) Notwithstanding chapter 453 or rules adopted pursuant thereto, in the event that a health care provider-patient relationship does not exist between the patient and the health care provider involved in a telehealth interaction between the patient and the health care provider, a telehealth mechanism may be used to establish a health care provider-patient relationship.

(e) All health maintenance organizations shall provide current and prospective insureds with written disclosure of coverages and benefits associated with telehealth services, including information on copayments, deductibles, or coinsurance requirements under a policy, contract, plan, or agreement. The information provided shall be current, understandable, and available prior to enrollment in a policy, contract, plan, or agreement and upon request after enrollment in the policy, contract, plan, or agreement.

(f) Services provided by telehealth pursuant to this section shall be consistent with all federal and state privacy, security, and confidentiality laws.

(g) For the purposes of this section:

“Distant site” means the location of the health care provider delivering services through telehealth at the time the services are provided.

“Health care provider” means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

“Interactive telecommunications system” has the same meaning as the term is defined in title 42 Code of Federal Regulations section 410.78(a).

“Originating site” means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider’s office, hospital, health care facility, a patient’s home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

“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. Except as provided through an interactive telecommunications system, standard telephone contacts, facsimile transmissions, or e-mail text, in combination or alone, do not constitute telehealth services.

### **Haw. Rev. Stat. § 453-1.3**

#### *Practice of telehealth*

[...] (h) Unless otherwise provided by law, reimbursement for behavioral health services provided through telehealth via an interactive telecommunications system shall be equivalent to reimbursement for the same services provided via in-person contact between a health care provider and a patient; provided that reimbursement for two-way, real-time audio-only communication technology for purposes of diagnosis, evaluation, or treatment of a mental health disorder to a patient in the patient’s home shall be equivalent to eighty per cent of the reimbursement for the same services provided via in-person contact between a health care provider and a patient. To be reimbursed for telehealth via an interactive telecommunications system using two-way, real-time audio-only communication technology in accordance with this subsection, the health care provider shall first conduct an in-person visit or a telehealth visit that is not audio only, within six months prior to the initial audio-only visit, or within twelve months prior to any subsequent audio-only visit. The telehealth visit required prior to the initial or subsequent audio-only visit in this subsection shall not be provided using audio-only communication.

[...] (j) For the purposes of this section:

“Distant site” means the location of the physician delivering services through telehealth at the time the services are provided.

“Interactive telecommunications system” has the same meaning as the term is defined in title 42 Code of Federal Regulations section 410.78(a).

“Originating site” means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a physician through telehealth, including but not limited to a physician’s office, hospital, health care facility, a patient’s home, and other non-medical environments such as school-based health centers, university-based health centers, or the work location of a patient.



“Telehealth” means the use of telecommunications 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 purposes of: delivering enhanced health care services and information while a patient is at an originating site and the physician is at a distant site; establishing a physician-patient relationship; evaluating a patient; or treating a patient. Except as provided through an interactive telecommunications system, standard telephone contacts, facsimile transmissions, or e-mail text, in combination or alone, do not constitute telehealth services.

#### **Haw. Rev. Stat. § 432:1-601.5**

##### *Mutual Benefit Societies - Coverage for Telehealth*

(a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without in-person contact with the health care provider.

(b) No mutual benefit society plan that is issued, amended, or renewed shall require in-person contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the mutual benefit society, and the health care provider.

(c) Reimbursement for services provided through telehealth via an interactive telecommunications system shall be equivalent to reimbursement for the same services provided via in-person contact between a health care provider and a patient; provided that reimbursement for two-way, real-time audio-only communication technology for purposes of diagnosis, evaluation, or treatment of a mental health disorder to a patient in the patient’s home shall be equivalent to eighty per cent of the reimbursement for the same services provided via in-person contact between a health care provider and a patient. To be reimbursed for telehealth via an interactive telecommunications system using two-way, real-time audio-only communication technology in



accordance with this subsection, the health care provider shall first conduct an in-person visit or a telehealth visit that is not audio only, within six months prior to the initial audio-only visit, or within twelve months prior to any subsequent audio-only visit. The telehealth visit required prior to the initial or subsequent audio-only visit in this subsection shall not be provided using audio-only communication. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

(e) All insurers shall provide current and prospective enrollees or subscribers with written disclosure of coverages and benefits associated with telehealth services, including information on copayments, deductibles, or coinsurance requirements under a policy, contract, plan, or agreement. The information provided shall be current, understandable, and available prior to the issuance of a policy, contract, plan, or agreement, and upon request after the policy, contract, plan, or agreement has been issued.

(f) Services provided by telehealth pursuant to this section shall be consistent with all federal and state privacy, security, and confidentiality laws.

(g) For the purposes of this section:

“Health care provider” means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health

providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

“Interactive telecommunications system” has the same meaning as the term is defined in title 42 Code of Federal Regulations section 410.78(a).

“Originating site” means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider’s office, hospital, health care facility, a patient’s home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

“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. Except as provided through an interactive telecommunications system, standard telephone contacts, facsimile transmissions, or e-mail text, in combination or alone, do not constitute telehealth services.

## IDAHO

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A

# Idaho

There are currently no commercial payer telehealth statutes in this state.



## ILLINOIS

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A

# Illinois

**Authority: 215 Ill. Comp. Stat. 5/356z.22**

## **215 Ill. Comp. Stat. 5/356z.22**

*Coverage for telehealth services*

Coverage for telehealth services

(a) For purposes of this Section:

“Asynchronous store and forward system” has the meaning given to that term in Section 5 of the Telehealth Act.

“Distant site” has the meaning given to that term in Section 5 of the Telehealth Act.

“E-visits” has the meaning given to that term in Section 5 of the Telehealth Act.

“Facility” means any hospital facility licensed under the Hospital Licensing Act or the University of Illinois Hospital Act, a federally qualified health center, a community mental health center, a behavioral health clinic, a substance use disorder treatment program licensed by the Division of Substance Use Prevention and Recovery of the Department of Human Services, or other building, place, or institution that is owned or operated by a person that is licensed or otherwise authorized to deliver health care services.

“Health care professional” has the meaning given to that term in Section 5 of the Telehealth Act.

“Interactive telecommunications system” has the meaning given to that term in Section 5 of the Telehealth Act. As used in this Section, “interactive telecommunications system” does not include virtual check-ins.

“Originating site” has the meaning given to that term in Section 5 of the Telehealth Act.

“Telehealth services” has the meaning given to that term in Section 5 of the Telehealth Act. As used in this Section, “telehealth services” do not include asynchronous store and forward systems, remote patient monitoring technologies, e-visits, or virtual check-ins.

“Virtual check-in” has the meaning given to that term in Section 5 of the Telehealth Act.

(b) An individual or group policy of accident or health insurance that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 102nd General Assembly shall cover telehealth services, e-visits, and virtual check-ins rendered by a health care professional when clinically appropriate and medically necessary to insureds, enrollees, and members in the same manner as any other benefits covered under the policy. An individual or group policy of accident or health insurance may provide reimbursement to a facility that serves as the originating site at the time a telehealth service is rendered

(1) An individual or group policy of accident or health insurance shall not:

(A) require that in-person contact occur between a health care professional and a patient before the provision of a telehealth service;

(B) require patients, health care professionals, or facilities to prove or document a hardship or access barrier to an in-person consultation for coverage and reimbursement of telehealth services, e-visits, or virtual check-ins;

(C) require the use of telehealth services, e-visits, or virtual check-ins when the health care professional has determined that it is not appropriate;

(D) require the use of telehealth services when a patient chooses an in-person consultation;

(E) require a health care professional to be physically present in the same room as the patient at the originating site, unless deemed medically necessary by the health care professional providing the telehealth service;

(F) create geographic or facility restrictions or requirements for telehealth services, e-visits, or virtual check-ins;

(G) require health care professionals or facilities to offer or provide telehealth services, e-visits, or virtual check-ins;

(H) require patients to use telehealth services, e-visits, or virtual check-ins, or require patients to use a separate panel of health care professionals or facilities to receive telehealth service, e-visit, or virtual check-in coverage and reimbursement; or

(I) impose upon telehealth services, e-visits, or virtual check-ins utilization review requirements that are unnecessary, duplicative, or unwarranted or impose any treatment limitations, prior authorization, documentation, or recordkeeping requirements that are more stringent than the requirements applicable to the same health care service when rendered in-person, except procedure code modifiers may be required to document telehealth.

(2) Deductibles, copayments, coinsurance, or any other cost-sharing applicable to services provided through telehealth shall not exceed the deductibles, copayments, coinsurance, or any other cost-sharing required by the individual or group policy of accident or health insurance for the same services provided through in-person consultation.

(3) An individual or group policy of accident or health insurance shall notify health care professionals and facilities of any instructions necessary to facilitate billing for telehealth services, e-visits, and virtual check-ins.

(d) For purposes of reimbursement, an individual or group policy of accident or health insurance that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 102nd General Assembly shall reimburse an in-network health care professional or facility, including a health care professional or facility in a tiered network, for telehealth services provided through an interactive telecommunications system on the same basis, in the same manner, and at the same reimbursement rate that would apply to the services if the services had been delivered via an in-person encounter by an in-network or tiered network health care professional or facility.

This subsection applies only to those services provided by telehealth that may otherwise be billed as an in-person service. This subsection is inoperative on and after January 1, 2028, except that this subsection is operative after that date with respect to mental

health and substance use disorder telehealth services.

(e) The Department and the Department of Public Health shall commission a report to the General Assembly administered by an established medical college in this State wherein supervised clinical training takes place at an affiliated institution that uses telehealth services, subject to appropriation.

The report shall study the telehealth coverage and reimbursement policies established in subsections (b) and (d) of this Section, to determine if the policies improve access to care, reduce health disparities, promote health equity, have an impact on utilization and cost-avoidance, including direct or indirect cost savings to the patient, and to provide any recommendations for telehealth access expansion in the future. An individual or group policy of accident or health insurance shall provide data necessary to carry out the requirements of this subsection upon request of the Department. The Department and the Department of Public Health shall submit the report by December 31, 2026. The established medical college may utilize subject matter expertise to complete any necessary actuarial analysis.

(f) Nothing in this Section is intended to limit the ability of an individual or group policy of accident or health insurance and a health care professional or facility to voluntarily negotiate alternate reimbursement rates for telehealth services. Such voluntary negotiations shall take into consideration the ongoing investment necessary to ensure these telehealth platforms may be continuously maintained, seamlessly updated, and integrated with a patient's electronic medical records.

g) An individual or group policy of accident or health insurance p that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 102nd General Assembly shall provide coverage for telehealth services for licensed dietitian nutritionists and certified diabetes educators who counsel diabetes patients in the diabetes patients' homes to remove the hurdle of transportation for diabetes patients to receive treatment, in accordance with the Dietitian Nutritionist Practice Act.

(h) Any policy, contract, or certificate of health insurance coverage that does not distinguish between in-network and out-of-network health care professionals and facilities shall be subject to this Section as though all health care professionals and facilities were in-network.

(i) Health care professionals and facilities shall determine the appropriateness of specific sites, technology platforms, and technology vendors for a telehealth service, as long as delivered services adhere to all federal and State privacy, security, and confidentiality laws, rules, or regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and the Mental Health and Developmental Disabilities Confidentiality Act.

(j) Nothing in this Section shall be deemed as precluding a health insurer from providing benefits for other telehealth services, including, but not limited to, services not required for coverage provided through an asynchronous store and forward system, remote

patient monitoring services, other monitoring services, or oral communications otherwise covered under the policy.

(k) There shall be no restrictions on originating site requirements for telehealth coverage or reimbursement to the distant site under this Section other than requiring the telehealth services to be medically necessary and clinically appropriate.

(l) The Department may adopt rules, including emergency rules subject to the provisions of Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section.



## INDIANA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A



# Indiana

**Authorities:** Ind. Code § 27-8-34 et seq., 27-13-7-22

## Ind. Code § 25-1-9.5-6

### *Telehealth*

Sec. 6. (a) As used in this chapter, “telehealth” means the delivery of health care services using interactive electronic communications and information technology, in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), including:

- (1) secure videoconferencing;
- (2) store and forward technology; or
- (3) remote patient monitoring technology;

between a provider in one (1) location and a patient in another location.

(b) The term does not include the use of the following unless the practitioner has an established relationship with the patient:

- (1) Electronic mail.
- (2) An instant messaging conversation.
- (3) Facsimile.
- (4) Internet questionnaire.
- (5) Internet consultation.

(c) The term does not include a health care service provided by:

- (1) an employee of a practitioner; or
- (2) an individual who is employed by the same entity that employs the practitioner; who is performing a health care service listed in section 2.5(a)(2), 2.5(a)(3), or 2.5(a)(4) of this chapter under the direction and that is customarily within the specific area of practice of the practitioner.

## Ind. Code § 27-8-34 et seq.

### *Coverage for Telemedicine Services*

#### Ind. Code § 27-8-34-1

##### *“Covered individual” defined*

As used in this chapter, “covered individual” means an individual who is entitled to coverage under a policy of accident and sickness insurance.

#### Ind. Code § 27-8-34-2

##### *“Health care services” defined*

As used in this chapter, “health care services” has the meaning set forth in IC 27-8-11-1.

#### Ind. Code § 27-8-34-3

##### *“Policy” defined*

As used in this chapter, “policy” means a policy of accident and sickness insurance (as defined in IC 27-8-5-1). The term does not include dental insurance or vision insurance.

#### Ind. Code § 27-8-34-4

##### *“Provider” defined*

As used in this chapter, “provider” has the meaning set forth in IC 27-8-11-1.

#### Ind. Code § 27-8-34-5

##### *“Telemedicine services” defined*

(a) As used in this chapter, “telehealth services” means health care services delivered by use of technology allowed under IC 25-1-9.5-6, including the following:

- (1) Medical exams and consultations.
- (2) Behavioral health, including substance abuse evaluations and treatment.

#### Ind. Code § 27-8-34-6

##### *Coverage of telehealth services; Conditions*

(a) A policy must provide coverage for telehealth services in accordance with the same clinical criteria as the policy provides coverage for the same health care services delivered in person.

(b) Coverage for telehealth services required by subsection (a) may not be subject to a dollar limit, deductible or coinsurance requirement that is less



favorable to a covered individual than the dollar limit, deductible or coinsurance requirement that applies to the same health care services delivered to a covered individual in person.

(c) Any annual or lifetime dollar limit that applies to telehealth services must be the same annual or lifetime dollar limit that applies in the aggregate to all items and services covered under the policy.

(d) A separate consent for telehealth services may not be required.

(e) If a policy provides coverage for telehealth services via:

- (1) secure videoconferencing;
- (2) store and forward technology; or
- (3) remote patient monitoring technology;

between a provider in one (1) location and a patient in another location, the policy may not require the use of a specific information technology application for those services.

#### **Ind. Code § 27-8-34-7**

##### *Coverage Parameters*

This chapter does not do any of the following:

- (1) Require a policy to provide coverage for a telehealth service that is not a covered health care service under the policy.
- (2) Require the use of telemedicine telehealth services when the treating provider has determined that telehealth services are inappropriate.
- (3) Prevent the use of utilization review concerning coverage for telehealth services in the same manner as utilization review is used concerning coverage for the same health care services delivered to a covered individual in person.

#### **Ind. Code § 27-13-7-22**

##### *Coverage for Telehealth Services Required*

(a) An individual contract or a group contract must provide coverage for telehealth services in accordance with the same clinical criteria as the individual

contract or the group contract provides coverage for the same health care services delivered to an enrollee in person.

(b) Coverage for telehealth services required by subsection (a) may not be subject to a dollar limit, copayment, or coinsurance requirement that is less favorable to an enrollee than the dollar limit, copayment, or coinsurance requirement that applies to the same health care services delivered to an enrollee in person.

(c) Any annual or lifetime dollar limit that applies to telehealth services must be the same annual or lifetime dollar limit that applies in the aggregate to all items and services covered under the individual contract or the group contract.

(d) This section does not do any of the following:

- (1) Require an individual contract or a group contract to provide coverage for a telehealth service that is not a covered health care service under the individual contract or group contract.
- (2) Require the use of telemedicine services when the treating provider has determined that telehealth services are inappropriate.
- (3) Prevent the use of utilization review concerning coverage for telehealth services in the same manner as utilization review is used concerning coverage for the same health care services delivered to an enrollee in person.

(e) A separate consent for telehealth services may not be required.

(f) If a policy provides coverage for telehealth services via:

- (1) secure videoconferencing;
- (2) store and forward technology; or
- (3) remote patient monitoring technology;

between a provider in one (1) location and a patient in another location, the policy may not require the use of a specific information technology application for those services.

## IOWA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A

# Iowa



**Authorities: Iowa Code §§ 514C.34, 514C.35**

## Iowa Code § 514C.34

*Health care services delivered by telehealth—coverage*

1. As used in this section, unless the context otherwise requires:

a. “Covered person” means the same as defined in section 514J.102.

b. “Facility” means the same as defined in section 514J.102.

c. “Health care professional” means the same as defined in section 514J.102.

d. “Health care services” means the same as defined in section 514J.102 and includes services for mental health conditions, illnesses, injuries, or diseases.

e. “Health carrier” means the same as defined in section 514J.102.

f. “Telehealth” means the delivery of health care services through the use of real-time interactive audio and video, or other real-time interactive electronic media, regardless of where the health care professional and the covered person are each located. “Telehealth” does not include the delivery of health care services delivered solely through an audio-only telephone, electronic mail message, or facsimile transmission.

2. Notwithstanding the uniformity of treatment requirements of section 514C.6, a policy, contract, or plan providing for 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 that are delivered through telehealth.

3. a. Health care services that are delivered by telehealth must be appropriate and delivered in accordance with applicable law and generally accepted health care practices and standards prevailing at the time the health care services are provided, including all rules adopted by the appropriate professional licensing board, pursuant to chapter 147, having oversight of the health care professional providing the health care services.

b. A health carrier shall not exclude a health care professional who provides services for mental health conditions, illnesses, injuries, or diseases and who is physically located out-of-state from participating as a provider, via telehealth, under a policy, plan, or contract offered by the health carrier in the state if all of the following requirements are met:

(1) The health care professional is licensed in this state by the appropriate professional licensing board and is able to deliver health care services for mental health conditions, illnesses, injuries, or diseases via telehealth in compliance with paragraph “a”.

(2) The health care professional is able to satisfy the same criteria that the health carrier uses to qualify a health care professional who is located in the state, and who holds the same license as the out-of-state professional, to participate as a provider, via telehealth, under a policy, plan, or contract offered by the health carrier in the state.

4. a. A health carrier shall reimburse a health care professional and a facility for health care services provided by telehealth to a covered person for a mental health condition, illness, injury, or disease on the same basis and at the same rate as the health carrier would apply to the same health care services for a mental health condition, illness, injury, or disease provided in person to a covered person by the health care professional or the facility.

b. As a condition of reimbursement pursuant to paragraph “a”, a health carrier shall not require that an additional health care professional be located in the same room as a covered person while health care services for a mental health condition, illness, injury, or disease are provided via telehealth by another health care professional to the covered person.

5. This section applies to the following classes of third-party payment provider policies, contracts, or plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2019:

a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.



b. An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

c. An individual or group health maintenance organization contract regulated under chapter 514B.

d. A plan established pursuant to chapter 509A for public employees.

6. This section shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

7. The commissioner of insurance may adopt rules pursuant to chapter 17A as necessary to administer this section.

### **Iowa Code § 514C.35**

#### *Behavioral health services provided in a school—coverage*

1. Notwithstanding the uniformity of treatment requirements of section 514C.6, a policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses shall not deny coverage or payment for behavioral health services, including behavioral health services provided via telehealth, solely because the services are delivered in a school.

2. Nothing in this section shall be interpreted to do any of the following:

a. Require an insurer to pay for behavioral health services that are otherwise excluded from coverage under a policy, contract, or plan.

b. Require an insurer to pay for behavioral health services that are provided by an individual employed by or under contract with a school district or an educational service agency in a regular full-time or

part-time position, or any other party that has not entered into a provider agreement with the insurer.

c. Prevent application of any other provision of a policy, contract, or plan.

3. This section applies to third-party payment provider policies, contracts, or plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2021, and to claims for reimbursement under such policies, contracts, or plans incurred on or after January 1, 2021.

4. For the purposes of this section:

a. "Behavioral health services" means services provided by a health care professional operating within the scope of the health care professional's practice which address mental, emotional, medical, or behavioral conditions, illnesses, diseases, or problems.

b. "Educational service agency" means a governmental agency or government entity which is established and operated exclusively for the purpose of providing educational services to one or more educational institutions.

c. "Health care professional" means a physician or other health care practitioner licensed, accredited, registered, or certified to perform specified health care services consistent with state law.

d. "School" means all of the following:

(1) Any school, other than a public school, that is accredited pursuant to section 256.11 for any and all levels for grades one through twelve.

(2) Any school directly supported in whole or in part by taxation.

(3) An area education agency established pursuant to chapter 273.

e. "School district" means a school district described in chapter 274.

f. "Telehealth" means the same as defined in section 514C.34.

## KANSAS

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A



# Kansas



**Authorities: Kan. Stat. §§ 40-2,211; 40-2,213**

## **Kan. Stat. § 40-2,211**

*Kansas telemedicine act; definitions*

(a) For purposes of Kansas telemedicine act:

(1) “Distant site” means a site at which a healthcare provider is located while providing healthcare services by means of telemedicine.

(2) “Healthcare provider” means a physician, licensed physician assistant, licensed advanced practice registered nurse or person licensed, registered, certified or otherwise authorized to practice by the behavioral sciences regulatory board.

(3) “Originating site” means a site at which a patient is located at the time healthcare services are provided by means of telemedicine.

(4) “Physician” means a person licensed to practice medicine and surgery by the state board of healing arts.

(5) “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.

(b) This section shall take effect on and after January 1, 2019.

## **Kan. Stat. § 40-2,213**

*Kansas telemedicine act; application of; coverage parity established*

(a) The provisions of this section shall apply to any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization that provides coverage for accident and health services and that is delivered, issued for delivery, amended or renewed on or after January 1, 2019. The provisions of this section shall also apply to the Kansas medical assistance program.

(b) No individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society, health maintenance organization or the Kansas medical assistance program shall exclude an otherwise covered healthcare service from coverage solely because such 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.

(c) The insured’s medical record shall serve to satisfy all documentation for the reimbursement of all telemedicine healthcare services, and no additional documentation outside of the medical record shall be required.

(d) Payment or reimbursement of covered healthcare 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.





(e) Nothing in this section shall be construed to:

(1) Prohibit an individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization that provides coverage for telemedicine or the Kansas medical assistance program from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered individual's health benefits plan;

(2) mandate coverage for a healthcare service delivered via telemedicine if such healthcare service is not already a covered healthcare service, when delivered by a healthcare provider subject to the terms and conditions of the covered individual's health benefits plan; or

(3) allow an individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization that provides coverage for telemedicine or the Kansas medical assistance program to require a covered individual to use telemedicine or in lieu of receiving an in-person healthcare service or consultation from an in-network provider.

(f) The provisions of K.S.A. 40-2248 and 40-2249a, and amendments thereto, shall not apply to this section.

(g) This section shall take effect on and after January 1, 2019.

## KENTUCKY

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Kentucky



**Authorities: Ky. Rev. Stat. §§ 211.332, 304.17A-138, 304.17A-005**

## **Ky. Rev. Stat. § 211.332**

### *Definitions*

[ . . . ] (5) “Telehealth” or “digital health”:

(a) Means a mode of delivering healthcare services through the use of telecommunication technologies, including but not limited to synchronous and asynchronous technology, remote patient monitoring technology, and audio-only encounters, by a health care provider to a patient or to another health care provider at a different location;

(b) Shall not include:

1. The delivery of health care services through electronic mail, text, chat, or facsimile unless a state agency authorized or required to promulgate administrative regulations relating to telehealth determines that health care services can be delivered via these modalities in ways that enhance recipient health and well-being and meet all clinical and technology guidelines for recipient safety and appropriate delivery of services; or

2. Basic communication between a health care provider and a patient, including but not limited to appointment scheduling, appointment reminders, voicemails, or any other similar communication intended to facilitate the actual provision of healthcare services either in-person or via telehealth; and

(c) Unless waived by the applicable federal authority, shall be delivered over a secure communications connection that complies with the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. secs. 1320d to 1320d-9.

## **Ky. Rev. Stat. § 304.17A-005**

### *Definitions*

[ . . . ] (23) “Health care provider” or “provider” means any:

(a) Advanced practice registered nurse licensed under KRS Chapter 314;

(b) Chiropractor licensed under KRS Chapter 312;

(c) Dentist licensed under KRS Chapter 313;

(d) Facility or service required to be licensed under

KRS Chapter 216B;

(e) Home medical equipment and services provider licensed under KRS Chapter 309;

(f) Optometrist licensed under KRS Chapter 320;

(g) Pharmacist licensed under KRS Chapter 315;

(h) Physician, osteopath, or podiatrist licensed under KRS Chapter 311;

(i) Physician assistant regulated under KRS Chapter 311; and

(j) Other health care practitioners as determined by the department by administrative regulations promulgated under KRS Chapter 13A;

## **Ky. Rev. Stat. § 304.17A-138**

*Telehealth coverage and reimbursement; requirements for health benefit plan; reimbursement for rural health clinics, federally qualified health centers, and federally qualified health center look-alikes; benefits subject to deductible, copayment, or coinsurance payment subject to provider network arrangements; audio-only encounters; administrative regulations*

(1) As used in this section:

(a) “Equivalent” means reimbursement in an amount equal to what reimbursement would have been had the service been furnished in person by that provider at the provider’s place of service;

(b) “Federally qualified health center” means the same as in 42 U.S.C. sec. 1396d;

(c) “Federally qualified health center look-alike” means an organization that meets all of the eligibility requirements of a federally qualified health center but does not receive federal grants issued pursuant to 42 U.S.C. sec. 254b;

(d) “Originating site” means the site at which a Medicaid beneficiary is physically located at the time a telehealth service or telehealth consultation is provided;

(e) “Provider” means the same as in KRS 304.17A-005 and also includes behavioral health professionals licensed under KRS Chapters 309, 319, and 335;



(f) “Telehealth” has the same meaning as in KRS 211.332; and

(g) “Rural health clinic” means the same as in 42 U.S.C. sec. 1395x.

(2) (a) A health benefit plan, issued or renewed on or after January 1, 2022, shall reimburse for covered services provided to an insured person through telehealth, including telehealth services provided by a home health agency licensed under KRS Chapter 216. Telehealth coverage and reimbursement shall, except as provided in paragraph (b) of this subsection, 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.

(b) Rural health clinics, federally qualified health centers, and federally qualified health center look-alikes shall be reimbursed as an originating site in an amount equal to that which is permitted under 42 U.S.C. sec. 1395m for Medicare-participating providers, if the insured was physically located at the rural health clinic, federally qualified health center, or federally qualified health center look-alike at the time of service or consultation delivery and the provider of the telehealth service or telehealth consultation is not: employed by the rural health clinic, federally qualified health center, or federally qualified health center look-alike.

(3) In accordance with KRS 211.336, a health benefit plan, issued or renewed on or after January 1, 2022:

(a) Shall not:

1. Require a provider to be physically present with a patient or client, unless the provider determines that it is necessary to perform those services in person;
2. Require prior authorization, medical review, or administrative clearance for telehealth that would not be required if a service were provided in person;
3. Require demonstration that it is necessary to provide services to a patient or client through telehealth;
4. 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;
5. Restrict or deny coverage of telehealth based solely on the communication technology or application used to deliver the telehealth services; or
6. Require a provider to be part of a telehealth network;

(b) Shall:

1. Require that telehealth services reimbursed under this section meet all clinical, technology, and medical coding guidelines for recipient safety and appropriate delivery of services established by the Department of Insurance or the provider’s professional licensure board;
2. Require a telehealth provider to be licensed in Kentucky, or as allowed under the standards and provisions of a recognized interstate compact, in order to receive reimbursement for telehealth services; and
3. Reimburse a rural health clinic, federally qualified health clinic, or federally qualified health center look-alike for covered telehealth services provided by a provider employed by the rural health clinic, federally qualified health clinic, or federally qualified health center look-alike, regardless of whether the provider was physically located on the premises of the rural health clinic, federally qualified health clinic, or federally qualified health clinic look-alike when the telehealth service was provided; and

(c) May utilize audits for medical coding accuracy in the review of telehealth services specific to audio-only encounters.

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

(5) Nothing in this section shall be construed to require a health benefit plan to:

(a) Provide coverage for telehealth services that are not medically necessary; or

(b) Reimburse any fees charged by a telehealth facility for transmission of a telehealth encounter.

(6) Providers and home health agencies are strongly encouraged to use audio-only encounters as a mode of delivering telehealth services when no other approved mode of delivering telehealth services is available.

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

## LOUISIANA

- Does the State Have a Statute?
- Coverage Provision?\*
- Reimbursement Provision? \*\*
- Unrestricted Originating Site?
- Member Cost-Shifting Protections? \*\*\*
- Provision for Narrow/Exclusive/In-Network Provider Limits? \*\*\*
- Remote Patient Monitoring?
- Store & Forward?

\* limited circumstances (originating site physician, PT, OT)

\*\*75% for originating site physician; 100% for PT and OT

\*\*\* But yes for PT and OT

Yes     No     Limited     N/A



# Louisiana

**Authorities: La. Stat. §§ 22:1821, 22:1841-45, 40:1223.3; 46 La. Admin. Code Pt XLV, 7503; 37 La. Admin. Code Pt XIII, 17947.**

## La. Stat. § 22:1821

*Payment of claims; health and accident policies; prospective review; penalties; self-insurers; telehealth reimbursement by insurers; prohibitions*

A. All claims arising under the terms of health and accident contracts issued in this state, except as provided in Subsection B of this Section, shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the policy, are furnished to the insurer unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. The insurer shall make payment at least every thirty days to the assured during that part of the period of his disability covered by the policy or contract of insurance during which the insured is entitled to such payments. Failure to comply with the provisions of this Section shall subject the insurer to a penalty payable to the insured of double the amount of the health and accident benefits due under the terms of the policy or contract during the period of delay, together with attorney fees to be determined by the court. Any court of competent jurisdiction in the parish where the insured lives or has his domicile, excepting a justice of the peace court, shall have jurisdiction to try such cases.

B. All claims for accidental death arising under the terms of health and accident contracts where such contracts insure against accidental death shall be settled by the insurer within sixty days of receipt of due proof of death and should the insurer fail to do so without just cause, then the amount due shall bear interest at the rate of six percent per annum from date of receipt of due proof of death by the insurer until paid.

C. Any person, partnership, corporation or other organization, or the State of Louisiana which provides or contracts to provide health and accident benefit coverage as a self-insurer for his or its employees, stockholders, or any other persons, shall be subject to the provisions of this Section, including the provisions relating to penalties and attorney fees, without regard to whether the person or organization is a commercial

insurer; however, this Section shall not apply to collectively bargained union welfare plans other than health and accident plans.

D.(1) In any event where the contract between an insurer or self-insurer and the insured is issued or delivered in this state and contains a provision that in non-emergency cases the insured is required to be prospectively evaluated through a pre-hospital admission certification, pre-inpatient service eligibility program, or any similar pre-utilization review or screening procedure prior to the delivery of contemplated hospitalization, inpatient or outpatient health care, or medical services which are prescribed or ordered by a duly licensed health care provider who possesses admitting and clinical staff privileges at an acute care health care facility or ambulatory surgical care facility, the insurer, self-insurer, third-party administrator, or independent contractor shall be held liable in damages to the insured only for damages incurred or resulting from unreasonable delay, reduction, or denial of the proposed medically necessary services or care according to the information received from the health care provider at the time of the request for a prospective evaluation or review by the duly licensed health care provider, as provided in the contract; such damages shall be limited solely to the physical injuries which are the direct and proximate cause of the unreasonable delay, reduction, or denial as further defined in this Subsection together with reasonable attorney fees and court costs.

(2)(a) Any insurer, health maintenance organization, preferred provider organization or other managed care organization requirement that the insured be prospectively evaluated through a pre-hospital admission certification, pre-inpatient service eligibility program, or any similar pre-utilization review or screening procedure shall be inapplicable to an emergency medical condition.

(b) Every insurer, health maintenance organization, preferred provider organization or other managed care organization which includes emergency medical services as part of its policy or contract, shall provide

coverage and shall subsequently pay providers for emergency medical services provided to an insured, enrollee, or patient who presents himself with an emergency medical condition. This Subparagraph shall not be construed to require coverage for illnesses, conditions, diseases, equipment, supplies or procedures or treatments which are not otherwise covered under the terms of the insured's policy or contract. The provisions of this Subparagraph shall not apply to hospital indemnity, disability, or renewable limited benefit supplemental health insurance policies authorized to be issued in this state.

(c) An insurer, health maintenance organization, preferred provider organization, or other managed care organization shall not retrospectively deny or reduce payments to providers for emergency medical services of an insured, enrollee, or patient even if it is determined that the emergency medical condition, initially presented is later identified through screening not to be an actual emergency, except in the following cases:

(i) Material misrepresentation, fraud, omission or clerical error.

(ii) Any payment reductions due to applicable copayments, coinsurance or deductibles which may be the responsibility of the insured.

(iii) Cases in which the insured does not meet the emergency medical condition definition, unless the insured has been referred to the emergency department by the insured's primary care physician or other agent acting on behalf of the insurer.

(d) Every insurer, health maintenance organization, preferred provider organization or other managed care organization shall inform its insureds, enrollees, patients and affiliated providers about all applicable policies related to emergency care access, coverage, payment and grievance procedures. It is the ultimate responsibility of the insurer, health maintenance organization or preferred provider organization to inform any contracted third party administrator, independent contractor or primary care provider about the emergency care provisions contained in this Paragraph.

(e) Failure to comply with the provisions of Subparagraphs (a), (b), and (c) of this Paragraph shall subject the insurer, health maintenance organization, preferred provider organization or other managed care organization to penalties as provided for in Subsection

A of this Section and to penalties for violations as provided in R.S. 22:1969.

(f) The provisions of this Paragraph shall not apply to medical benefit plans that are established under and regulated by the Employment Retirement Income Security Act of 1974.

(g) As used in this Paragraph, the following definitions shall apply:

(i) "Emergency medical condition" is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in:

(aa) Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(bb) Serious impairment to bodily function.

(cc) Serious dysfunction of any bodily organ or part.

(ii) "Emergency medical services" are those medical services necessary to screen, evaluate and stabilize an emergency medical condition.

(iii) "Managed care organization" means a licensed insurance company, hospital or medical benefit plan or program, health maintenance organization, integrated health care delivery system, an employer or employee organization or a managed care contractor which operates a managed care plan. A managed care organization may include, but is not limited to, a preferred provider organization, health maintenance organization, exclusive provider organization, independent practice association, clinic without walls, management services organization, managed care services organization, physician hospital organization and hospital physician organization.

(iv) "Managed care plan" means a plan operated by a managed care entity which provides for the financing and delivery of health care and treatment services to individuals enrolled in such plan through its own employed health care providers or contracting with selected specific providers that conform to explicit selection, standards, or both. A managed care plan also customarily has a formal organizational structure for continual quality assurance, a certified utilization review program, dispute resolution, and financial

incentives for individual enrollees to use the plan's participating providers and procedures.

(3)(a) For the purposes of this Subsection, a period of two working days from the time of the duly licensed health care provider's request to the insurer, self-insurer, third party administrator or independent contractor for a pre-hospital admission or pre-inpatient service eligibility certification or any similar pre-utilization review or screening procedure confirmation until the receipt by the duly licensed health care provider of such insurer's, self-insurer's, third party administrator's or independent contractor's certification, approval or denial of the contemplated hospitalization, inpatient or outpatient health care, or medical services, shall not be considered unreasonable.

(b) For the purposes of this Subsection, a period in excess of two working days from the time of the duly licensed health care provider's request to the insurer, self-insurer, third party administrator or independent contractor for a pre-hospital admission or pre-inpatient service eligibility certification or any similar pre-utilization review or screening procedure confirmation until the receipt by the duly licensed health care provider of such insurer's, self-insurer's, third party administrator's, or independent contractor's certification, approval, or denial of the contemplated hospitalization, inpatient or outpatient health care, or medical services may be considered unreasonable depending on the circumstances of each individual case.

(c) For the purposes of this Subsection, the term "unreasonable reduction" shall mean the decreasing or limiting of either of the following:

(i) Previously certified or approved health care or medical services as contracted for between the insurer and insured.

(ii) Continued hospitalization and medical services without providing a procedure or method for certifying an extension of hospitalization and medical services by the insurer's or self-insurer's review or screening procedure in the event of continued hospitalization or medical attention, or both, as deemed medically necessary according to current established medical criteria.

(d) For the purposes of this Subsection, an "unreasonable denial" shall mean the failure to do any of the following:

(i) Review a request from a duly licensed health care provider by the insurer's or self-insurer's review or screening procedure.

(ii) Review a request from the insured within the time period as provided for in the contract between the insurer or self-insurer and the insured, which time period shall not exceed two work days as provided for in Subparagraph (a) of this Paragraph.

(iii) Deliver the contracted for health care or medical services previously certified or approved by the insurer's or self-insurer's review or screening procedure for medically necessary treatment or care as mandated by and provided for in the contract between the insurer or self-insurer and the insured.

(iv) Review a request from a duly licensed health care provider by the insurer's or self-insurer's review or screening procedure for an extension of the original certified or approved duration of health care or medical services.

(v) Extend the original certified or approved duration of hospitalization, health care or medical services requested by a duly licensed health care provider by the insurer's or self-insurer's review or screening procedure when treatment or care is deemed medically necessary according to current established medical criteria.

(e) For the purposes of this Subsection, "medically necessary treatment or care" shall mean contemplated hospitalization, inpatient or outpatient health care, or medical services recommended for appropriate treatment or care in accordance with nationally accepted current medical criteria.

(4) Any court of competent jurisdiction in the parish where the insured lives or has his domicile, excepting a justice of the peace court, has jurisdiction of cases arising under the provisions of Paragraph (1) of this Subsection.

E. No action for the recovery of penalties or attorney fees provided in this Section shall be brought after the expiration of one year after the date proofs of loss are required to be filed.

F. (1) Notwithstanding any provision of any policy or contract of insurance or health benefits issued, whenever the policy provides for payment, benefit or reimbursement for any healthcare service, including but not limited to diagnostic testing, treatment, referral or consultation, and the healthcare service is performed via transmitted electronic imaging or

telehealth, the payment, benefit or reimbursement under the policy or contract shall not be denied to a licensed physician conducting or participating in the transmission at the originating healthcare facility or terminus who is physically present with the individual who is the subject of the electronic imaging transmission and is contemporaneously communicating and interacting with a licensed physician at the receiving terminus of the transmission. The payment, benefit or reimbursement to the licensed physician at the originating facility or terminus shall not be less than seventy-five percent of the reasonable and customary amount of payment, benefit or reimbursement which that licensed physician receives for an intermediate office visit.

(2) Any healthcare service proposed to be performed or performed via transmitted electronic imaging or telehealth pursuant to this Subsection shall be subject to the applicable utilization review criteria and requirements of the insurer. Terminology in a health and accident insurance policy or contract that either discriminates against or prohibits such a method of transmitted electronic imaging or telehealth shall be void as against public policy of providing the highest quality health care to the citizens of the state.

(3) The provisions of this Subsection shall not apply to limited benefit health insurance policies or contracts authorized to be issued in the state.

G. (1) Notwithstanding any provision of law to the contrary, an insurer, managed care company, or other payor shall not set a maximum dollar amount of reimbursement for noninvasive ventilators or ventilation treatments properly ordered and being used in an appropriate care setting.

(2)(a) The Centers for Medicare and Medicaid Services (CMS) classify ventilators as equipment requiring frequent and substantial servicing to avoid risk to patient health. The durable medical equipment (DME) supplier shall be required to provide the patient regular and comprehensive service and preventative maintenance by a certified or registered respiratory therapist. This service shall include but is not limited to masks, tubing, tracheotomy supplies, filters, and other supporting supplies and equipment. Reimbursement shall be at a rate negotiated with the payors to insure that a sustained level of service can be provided to the patient.

(b) Notwithstanding any provision of law to the contrary, an insurer, managed care company,

subcontractor, third-party administrator or other payor shall reimburse DME suppliers for home use noninvasive and invasive ventilators on a continuous monthly payment basis for the duration of medical need throughout a patient's valid prescription period.

## **La. Stat. § 22:1841**

### *Definitions*

For purposes of this Subpart, the following definitions apply:

(1) "Health coverage plan" means any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract, or other agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type in this state, including a group insurance plan, a self-insurance plan, and the Office of Group Benefits programs.

"Health coverage plan" shall not include a plan providing coverage for excepted benefits as defined in R.S. 22:1061, limited benefit health insurance plans, and short-term policies that have a term of less than twelve months.

(2) "Medication adherence management services" means the monitoring of a patient's conformance with the healthcare provider's medication plan with respect to timing, dosing, and frequency of medication-taking through electronic transmission of data in a remote patient monitoring services program.

(3) "Platform" means the technology, system, software, application, modality, or other method through which a healthcare provider remotely interfaces with a patient when providing a healthcare service or procedure as a telehealth healthcare service.

(4) "Remote patient monitoring services" means the delivery of healthcare services using telecommunications technology to enhance the delivery of health care, including but not limited to all of the following:

(a) Monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, and other condition-specific data, such as blood glucose.

(b) Medication adherence monitoring.

(c) Interactive video conferencing with or without digital image upload.

(5) “Telehealth” shall have the same meaning as defined in R.S. 40:1223.3 and may include audio-only conversations as provided for in R.S. 40:1223.3(5).

#### **La. Stat. § 22:1842**

##### *Telehealth healthcare services statement*

A. (1) Each issuer of a health coverage plan shall display in a conspicuous manner on the health coverage plan issuer’s website information regarding how to receive covered telehealth healthcare services and remote patient monitoring services.

(2) A link clearly identified on the health coverage plan’s issuer’s website to the information required pursuant to this Subsection shall be sufficient to meet the requirements of this Section.

B. This Section shall not require an issuer of a health coverage plan to display negotiated contract payment rates for healthcare providers who contract with the issuer to provide telehealth healthcare services.

#### **La. Stat. § 22:1843**

##### *Remote patient monitoring services*

A. The legislature hereby finds all of the following:

(1) Remote patient monitoring services aim to allow more people to remain at home or in other nontraditional clinical settings and to improve the quality and cost of their care, including prevention of more costly care.

(2) The goal of remote patient monitoring services provided through telehealth is to coordinate primary, acute, behavioral, and long-term social service needs for high-need, high-cost patients.

B. To receive reimbursement for the delivery of remote patient monitoring services through telehealth, all of the following conditions shall be met:

(1) The services shall consist of all of the following:

(a) An assessment, problem identification, and evaluation which includes all of the following:

(i) Assessment and monitoring of clinical data including but not limited to appropriate vital signs, pain levels, and other biometric measures specified in the plan of care and an assessment of responses to previous changes in the plan of care.

(ii) Detection of condition changes based on the telehealth encounter that may indicate the need for a change in the plan of care.

(b) Implementation of a management plan through one or more of the following:

(i) Teaching regarding medication management as appropriate based on the telehealth findings for that encounter.

(ii) Teaching regarding other interventions as appropriate to both the patient and the caregiver.

(iii) Management and evaluation of the plan of care including changes in visit frequency or addition of other skilled services.

(iv) Coordination of care with the ordering healthcare provider regarding the telehealth findings.

(v) Coordination and referral to other healthcare providers as needed.

(vi) Referral for an in-person visit or the emergency room as needed.

(2) The entity that will provide the remote monitoring services shall have protocols in place to address all of the following:

(a) Authentication and authorization of users.

(b) A mechanism for monitoring, tracking, and responding to changes in the patient’s clinical condition.

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<sup>5</sup> (3) “Excepted benefits” means benefits under one or more of the following:

(a) Benefits not subject to requirements:

(i) Coverage only for accident, or disability income insurance, or any combination.

(ii) Coverage issued as a supplement to liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Workers’ compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in regulations issued by the commissioner of insurance under the Administrative Procedure Act, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) Benefits not subject to requirements if offered separately:

(i) Limited scope dental or vision benefits.

(c) A standard of acceptable and unacceptable parameters for the patient's clinical parameters, which can be adjusted based on the patient's condition.

(d) How monitoring staff will respond to abnormal parameters for the patient's vital signs, symptoms, or lab results.

(e) The monitoring, tracking, and responding to changes in the patient's clinical condition.

(f) The process for notifying the prescribing healthcare provider for significant changes in the patient's clinical signs and symptoms.

(g) The prevention of unauthorized access to the system or information.

(h) System security, including the integrity of information that is collected, program integrity, and system integrity.

(i) Information storage, maintenance, and transmission.

(j) Synchronization and verification of patient profile data.

(k) Notification of the patient's discharge from the remote patient monitoring services or the deinstallation of the remote patient monitoring unit.

C. A health coverage plan may require an authorization request for remote patient monitoring prior to the health coverage plan's approval of coverage for a specified healthcare service.

#### La. Stat. § 22:1844

##### *Exclusions*

The provisions of this Subpart shall not apply to any plan providing coverage for excepted benefits as defined in R.S. 22:1061, limited benefit health insurance plans, and short-term policies that have a term of less than twelve months.

#### La. Stat. § 22:1845.1

Telehealth coverage and reimbursement for physical therapy; prohibitions and limitations; exceptions; rulemaking

A. A health coverage plan shall pay for covered physical therapy services provided via telehealth to an insured person.

Telehealth coverage and payment shall be equivalent to the coverage and payment for the same service provided in person unless the telehealth provider and the health coverage plan contractually agree to an alternative payment rate for telehealth services.

B. Benefits for a service provided as telehealth may be subject to a deductible, copayment, or coinsurance. A deductible, copayment, or coinsurance applicable to a particular service provided through telecommunications technology shall not exceed the deductible, copayment, or coinsurance required by the health coverage plan for the same service when provided in person.

C. A health coverage plan shall not impose an annual dollar maximum on coverage for healthcare services covered under the health coverage plan that are provided as telehealth, other than an annual dollar maximum that applies to the same services when provided in person by the same provider.

D. A health coverage plan shall require a healthcare professional to be licensed or otherwise authorized to practice physical therapy in this state to be eligible to receive payment for telehealth services.

E. Payment made pursuant to this Section shall be consistent with any provider network arrangements that have been established for the health coverage plan.

F. A health coverage plan shall not do any of the following:

(1) Require a previously established in-person relationship or the provider to be physically present

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(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Such other similar, limited benefits as specified in reasonable regulations issued by the commissioner of insurance.

(c) Benefits not subject to requirements if offered as independent, non-coordinated benefits:

(i) Coverage only for a specified disease or illness.

(ii) Hospital indemnity or other fixed indemnity insurance.

(d) Benefits not subject to requirements if offered as a separate insurance policy:

(i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act.

(ii) Insurance coverage supplemental to military health benefits.

(iii) Similar supplemental coverage provided under a group health plan. La. Stat. Ann. § 22:1061(3).

with a patient or client, unless the provider determines that it is necessary to perform that service in person.

(2) Require prior authorization, medical review, or administrative clearance for telehealth that would not be required if that service were provided in person

(3) Require demonstration that it is necessary to provide services to a patient or client as telehealth.

(4) 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.

(5) Restrict or deny coverage based solely on the communication technology or application used to provide the telehealth service; however, a health coverage plan may restrict physical therapy services via telehealth when the services are being provided solely by telephone.

(6) Impose specific requirements or limitations on the technologies used to provide telehealth services; however, a health coverage plan may require the provider to demonstrate that the technology used to provide telehealth services is both safe and secure.

(7) Impose additional certification, location, or training requirements as a condition of payment for telehealth services; however, this Paragraph does not prohibit a health coverage plan from providing additional reimbursement incentives to providers with an enhanced certification, training, or accreditation.

(8) Require a provider to be part of a telehealth network.

G. Nothing in this Section shall be construed to require a health coverage plan to do either of the following:

(1) Provide coverage for telehealth services that are not medically necessary.

(2) Reimburse any fees charged by a telehealth facility for transmission of a telehealth encounter.

H. A health coverage plan is not required to provide coverage or reimbursement for any of the following procedures or services provided via telehealth:

(1) A modality that is a type of electrical, thermal, or mechanical energy.

(2) Manual therapy, massage, dry needling, or other invasive procedures.

I. The department may take any action authorized in this Title to enforce the provisions of this Section and the commissioner may, in compliance with the Administrative Procedure Act, R.S. 49:950 et seq., promulgate and adopt rules as are necessary or advisable to effectuate the provisions of this Section.

J. For purposes of this Section, the following definitions apply:

(1) "Health coverage plan" has the same meaning as provided for in R.S. 22:1841.

(2) "Telehealth" has the same meaning as provided for in R.S. 40:1223.3.

### **La. Stat. § 22:1845.2**

*Telehealth coverage and reimbursement for occupational therapy; prohibitions and limitations; exceptions; rulemaking*

A. A health coverage plan shall pay for covered occupational therapy services provided via telehealth to an insured person. Telehealth coverage and payment shall be equivalent to the coverage and payment for the same service provided in person unless the telehealth provider and the health coverage plan contractually agree to an alternative payment rate for telehealth services.

B. Benefits for a service provided as telehealth may be subject to a deductible, copayment, or coinsurance. A deductible, copayment, or coinsurance applicable to a particular service provided through telecommunications technology shall not exceed the deductible, copayment, or coinsurance required by the health coverage plan for the same service when provided in person.

C. A health coverage plan shall not impose an annual dollar maximum on coverage for healthcare services covered under the health coverage plan that are provided as telehealth, other than an annual dollar maximum that applies to the same services when provided in person by the same provider.

D. A health coverage plan shall require a healthcare professional to be licensed or otherwise authorized to practice occupational therapy in this state to be eligible to receive payment for telehealth services.

E. Payment made pursuant to this Section shall be consistent with any provider network arrangements that have been established for the health coverage plan.

F. A health coverage plan shall not do any of the following:

- (1) Require a previously established in-person relationship or the provider to be physically present with a patient or client, unless the provider determines that it is necessary to perform that service in person.
- (2) Require prior authorization, medical review, or administrative clearance for telehealth that would not be required if that service were provided in person.
- (3) Require demonstration that it is necessary to provide services to a patient or client as telehealth.
- (4) 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.
- (5) Restrict or deny coverage based solely on the communication technology or application used to provide the telehealth service; however, a health coverage plan may restrict occupational therapy services via telehealth when the services are being provided solely by telephone.
- (6) Impose specific requirements or limitations on the technologies used to provide telehealth services; however, a health coverage plan may require the provider to demonstrate that the technology used to provide telehealth services is both safe and secure.
- (7) Impose additional certification, location, or training requirements as a condition of payment for telehealth services; however, this Paragraph does not prohibit a health coverage plan from providing additional reimbursement incentives to providers with an enhanced certification, training, or accreditation.
- (8) Require a provider to be part of a telehealth network.

G. Nothing in this Section shall be construed to require a health coverage plan to do either of the following:

- (1) Provide coverage for telehealth services that are not medically necessary.
- (2) Reimburse any fees charged by a telehealth facility for transmission of a telehealth encounter.

H. A health coverage plan is not required to provide coverage or reimbursement for any of the following procedures or services provided via telehealth:

- (1) A modality that is a type of electrical, thermal, or mechanical energy.

(2) Manual therapy, massage, dry needling, or other invasive procedures.

I. The department may take any action authorized in this Title to enforce the provisions of this Section and the commissioner may, in compliance with the Administrative Procedure Act, R.S. 49:950 et seq., promulgate and adopt rules as are necessary or advisable to effectuate the provisions of this Section.

J. For purposes of this Section, the following definitions apply:

- (1) "Health coverage plan" has the same meaning as provided for in R.S. 22:1841.
- (2) "Telehealth" has the same meaning as provided for in R.S. 40:1223.3.

### **La. Stat. § 40:1223.3**

#### *Louisiana Telehealth Access Act: Definitions*

As used in this Part, the following terms have the meaning ascribed in this Section:

- (1) "Asynchronous store and forward transfer" means the transmission of a patient's medical information from an originating site to the provider at the distant site without the patient being present.
- (2) "Distant site" means the site at which the healthcare provider delivering the service is located at the time the service is provided via a telecommunications system.
- (3) "Healthcare provider" means a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed or certified by this state to practice medicine or provide health care or healthcare professional services which may be provided by telehealth in the ordinary course of business or practice of a profession.
- (4) "Originating site" means the location of the patient at the time the service is furnished via a telecommunications system or when the asynchronous store and forward transfer occurs.
- (5) "Synchronous interaction" means communication through interactive technology that enables a healthcare provider and a patient at two locations separated by distance to interact via two-way video and audio transmissions simultaneously.
- (6)(a) "Telehealth" means healthcare services, including behavioral health services, provided by a healthcare provider, as defined in this Section, to a person through the use of electronic communications,



information technology, asynchronous store-and-forward transfer technology, or synchronous interaction between a provider at a distant site and a patient at an originating site, including but not limited to assessment of, diagnosis of, consultation with, treatment of, and remote monitoring of a patient, and transfer of medical data. The term “telehealth” shall not include any of the following:

(i) Electronic mail messages and text messages that are not compliant with applicable requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, 42 U.S.C. 1320d et seq.

(ii) Facsimile transmissions.

(b) For purposes of this Paragraph, “behavioral health services” means all of the following:

(i) Behavioral health services as defined in R.S. 40:2153 that are appropriate for the patient and delivered by a licensed mental health professional, acting within the scope of applicable state laws and his professional license for services identified by the Louisiana Department of Health, to treat mental illness or substance use.

(ii) Services provided by a behavioral health provider who works for a licensed agency or credentialed provider which provides community psychiatric support and treatment services or psychosocial rehabilitation services as defined in R.S. 40:2162.

#### **46 La. Admin. Code Pt XLV, 7503**

##### *Definitions*

A. As used in this Chapter and in § 408 of these rules, unless the content clearly states otherwise, the following words and terms shall have the meanings specified.

[...]

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.

#### **37 La. Admin. Code Pt XIII, 17947**

##### *Telemedicine Access: Requirements in the Event of a Declared Emergency*

A. Health insurance issuers shall waive any coverage limitations restricting telemedicine access to providers included within a plan’s telemedicine network.

B. Health insurance issuers shall waive any requirement that the patient and provider have a prior relationship in order to have services delivered through telemedicine.

C. Health insurance issuers shall cover mental health services provided by telemedicine consultation to the same extent the services would be covered if provided through an in-person consultation. This shall not be interpreted to require coverage of telemedicine services that cannot be appropriately provided remotely.

D. Health insurance issuers shall waive any requirement limiting coverage to provider-to-provider consultations only and shall cover telemedicine consultations between a patient and a provider to the extent the same services would be covered if provided in person.



## MAINE

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Maine

**Authority: Me. Rev. Stat. tit. 24-A, § 4316, ME Insurance Bulletin No. 459**

## **Me. Rev. Stat. tit. 24-A, § 4316**

### *Coverage for telehealth services*

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. “Mobile health device” means a wearable device used to track health and wellness, including, but not limited to, a heart rate and respiratory monitor, an electrocardiogram monitor and a glucose monitor.

A-1. “Medicare” means the “Health Insurance for the Aged Act,” Title XVIII of the Social Security Amendments of 1965, as amended.

B. “Store and forward transfers” means transmission of an enrollee’s recorded health history through a secure electronic system to a provider.

B-1. “Asynchronous encounters” means the interaction or consultation between an enrollee and the enrollee’s provider or between providers regarding the enrollee through a system with the ability to store digital information, including, but not limited to, still images, video, audio and text files, and other relevant data in one location and subsequently transmit such information for interpretation at a remote site by health professionals without requiring the simultaneous presence of the patient or the health professionals.

B-2. “Synchronous encounters” means a real-time interaction conducted with interactive audio or video connection between an enrollee and the enrollee’s provider or between providers regarding the enrollee.

C. “Telehealth,” as it pertains to the delivery of health care services, means the use information technology and includes, synchronous encounters, asynchronous encounters, store and forward transfers and telemonitoring.

D. “Telemonitoring,” as it pertains to the delivery of health care services, means the use of information technology to remotely monitor an enrollee’s health status via electronic means, allowing the provider to track the enrollee’s health data over time. Telemonitoring may be synchronous or asynchronous.

2. Parity for telehealth services. A carrier offering a health plan in this State may not deny coverage on the basis that the health care service is provided through telehealth if the health care service would be covered if it were provided through in-person consultation between an enrollee and a provider and as long as the provider is acting within the scope of practice of the provider’s license and in accordance with rules adopted by the board, if any, that issued the provider’s license related to standards of practice for the delivery of a health care service through telehealth. Coverage for health care services provided through telehealth must be determined in a manner consistent with coverage for health care services provided through in-person consultation. If an enrollee is eligible for coverage and the delivery of the health care service through telehealth is medically appropriate, a carrier may not deny coverage for telehealth services.

A carrier may offer a health plan containing a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to a comparable service provided through in-person consultation. A carrier may not exclude a health care service from coverage solely because such health care service is provided only through a telehealth encounter, as long as telehealth is appropriate for the provision of such health care service.

3. Coverage for telehealth services. Except as provided in this section, a carrier shall provide coverage for any medically necessary health care service delivered through telehealth as long as the following requirements are met.

A. The health care service is otherwise covered under an enrollee’s health plan.

B. The health care service delivered by telehealth is of comparable quality to the health care service delivered through in-person consultation.

C. Prior authorization is required for telehealth services only if prior authorization is required for the corresponding covered health care service. An

in-person consultation prior to the delivery of services through telehealth is not required.

D. Coverage for telehealth services is not limited in any way on the basis of geography, location or distance for travel.

E. The carrier shall require that a clinical evaluation is conducted either in person or through telehealth before a provider may write a prescription that is covered.

F. The carrier shall provide coverage for the treatment of 2 or more persons who are enrolled in the carrier's health plan at the same time through telehealth, including counseling for substance use disorders involving opioids.

G. The carrier may not place any restriction on the prescribing of medication through telehealth by a provider whose scope of practice includes prescribing medication that is more restrictive than any requirement in state and federal law for prescribing medication through in-person consultation.

4. Telemonitoring requirements. A carrier shall provide coverage for telemonitoring if:

A. The telemonitoring is intended to collect an enrollee's health-related data, including, but not limited to, pulse and blood pressure readings, that assist a provider in monitoring and assessing the enrollee's medical condition;

B. The telemonitoring is medically necessary for the enrollee;

C. The enrollee is cognitively and physically capable of operating the mobile health devices or the enrollee has a caregiver willing and able to assist with the mobile health devices; and

D. The enrollee's residence is suitable for telemonitoring. If the residence appears unable to support telemonitoring, the telemonitoring may not be provided unless necessary adaptations are made.

6. Utilization review. This section does not prohibit or limit a carrier from conducting a utilization review for telehealth services as long as the utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service.

7. Provider eligibility. In order to be eligible for reimbursement under this section, a provider providing health care services through telehealth must

be acting within the scope of the provider's license. A carrier may not impose additional credentialing requirements or prior approval requirements for a provider as a condition of reimbursement for health care services provided under this section unless those credentialing requirements or prior approval requirements are the same as those imposed for a provider that does not provide health care services through telehealth.

8. Telehealth equipment. A carrier may not require a provider to use specific telecommunications technology and equipment as a condition of coverage under this section as long as the provider uses telecommunications technology and equipment that comply with current industry interoperability standards and that comply with standards required under the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and regulations promulgated under that Act.

9. Medicare coverage policy. A carrier may provide coverage for health care services delivered through telehealth that is consistent with the Medicare coverage policy for interprofessional Internet consultations. If a carrier provides coverage consistent with the Medicare coverage policy for interprofessional Internet consultations, the carrier may also provide coverage for interprofessional Internet consultations that are provided by a federally qualified health center or rural health clinic as defined in 42 United States Code, Section 1395x, subsection (aa)(1993).

10. Network adequacy. The availability of health care services through telehealth may not be considered for the purposes of demonstrating the adequacy of a carrier's network pursuant to section 4303, subsection 1 and Bureau of Insurance Rule Chapter 850: Health Plan Accountability.

### **ME Insurance Bulletin No. 459 (2021)**

#### *Insurance Coverage for Services Provided Through Telehealth*

On June 21, 2021, "An Act Regarding Telehealth Regulations" took effect as emergency legislation, [P.L. 2021, ch. 291 (L.D. 791)] amending the laws relating to provider licensure, insurance coverage, and MaineCare coverage for telehealth services. This Bulletin summarizes the new telehealth law and its impact on insurance coverage.

What is telehealth? Telehealth is a method of delivering health care services remotely. Telehealth is not a

separate type of health care service or practice.

**Telehealth Defined:** The new law defines “telehealth services” as health care services delivered through the use of information technology. [The version of the definition in the Insurance Code is found at 24-A M.R.S. § 4316(1)(C)]. The law refers to “information technology” generally, rather than specifying which particular technologies constitute telehealth, in order to anticipate technological advancements. The law updates the statutory definitions of telehealth and makes them more uniform across different titles of the Maine Revised Statutes.

The new definition removes the former distinction in the Insurance Code between “telehealth” and “telephonic services.” [See former 24-A M.R.S. § 4316(5), repealed by Chapter 291]. Thus, a health service delivered by telephone is now a subset of “telehealth.” This does not mean that all phone calls between patients and providers are now considered “telehealth” for the purposes of provider reimbursement. However, the phone can be a modality for “the delivery of health care services,” to the extent consistent with other applicable laws, standards of practice, and any rules enacted by the respective licensing boards. The law continues to define telehealth services as including “telemonitoring,” but the definition has been broadened to include use of information technology to remotely monitor any patient’s health status via electronic means, wherever the patient is located.

**Compliance with other applicable laws:** The new telehealth law does not create any new insurance coverage mandates, and does not place any requirements on providers to deliver health care services through the use of information technology. It is important to keep in mind that insurance laws do not expand or restrict what services health care providers may provide, or dictate how those services may be delivered.

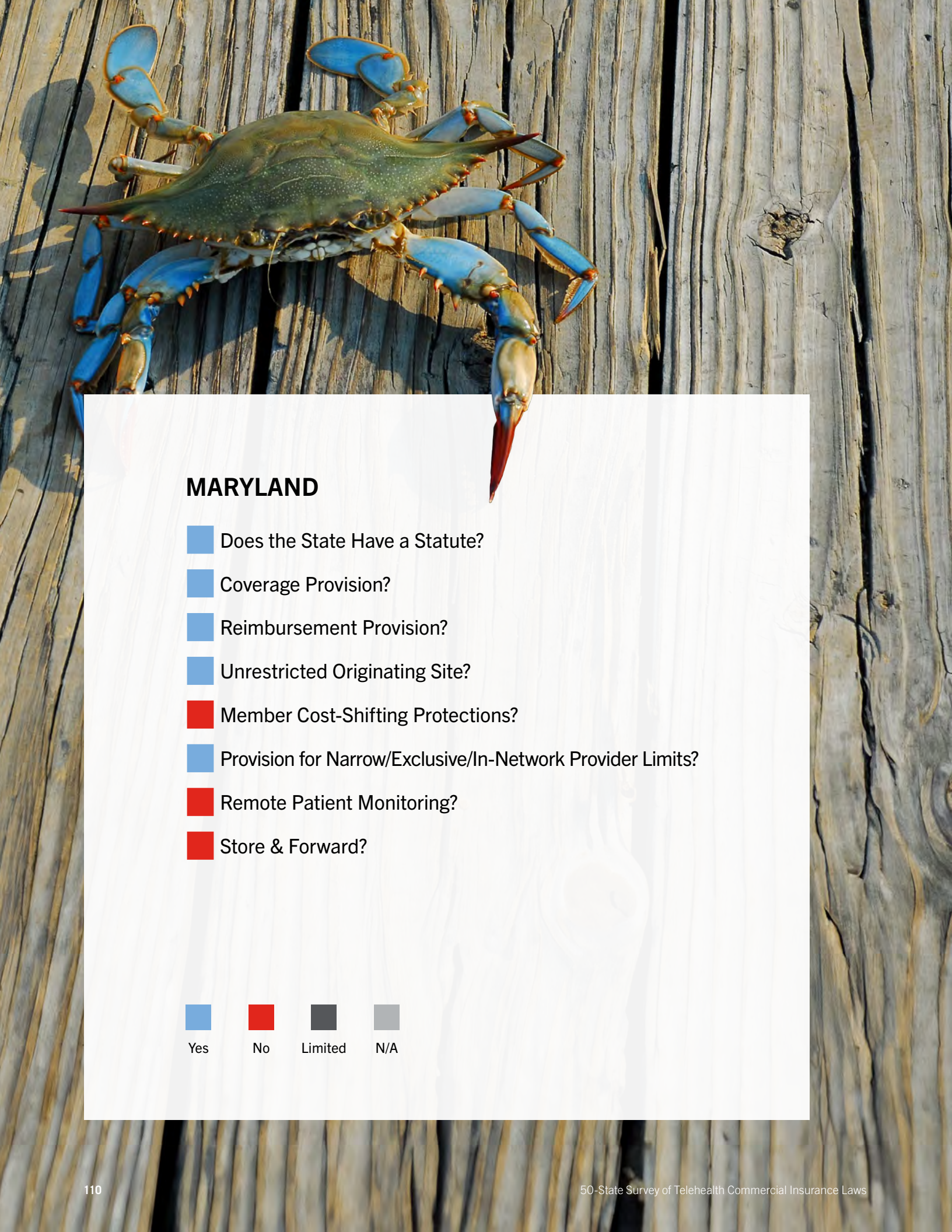
When providing telehealth services, health care providers may only act within the scope of their respective licenses, and must comply with applicable standards of practice and board rules regarding telehealth, if any. Health care providers must also comply with all state and federal confidentiality laws, such as the privacy regulations adopted under the Health Insurance Portability and Accountability Act (HIPAA).

**Parity in insurance coverage:** The Maine Insurance Code has mandated telehealth coverage for more than ten years. The recent legislation did not change the requirement that health insurance carriers in Maine may not deny coverage when “an enrollee is eligible for coverage and the delivery of the health care service through telehealth is medically appropriate.” [24-A M.R.S. § 4316(2)]. Carriers must still determine coverage for telehealth services “in a manner consistent with coverage for health care services provided through in-person consultation,” and may not require enrollees to pay higher cost sharing for telehealth services. As noted earlier, the separate, more restrictive standards for coverage of “telephonic services” has been repealed. In addition, the law now expressly states that coverage is only required when providers delivering telehealth services are acting within the scope of their licenses and following any applicable rules of practice. [24-A M.R.S. § 4316(2), as amended by Chapter 291]. The only other material change to the coverage parity requirement is that the new law prohibits any carrier-imposed restrictions on coverage for prescribing medication through telehealth that are more restrictive than the requirements imposed by law for prescribing medication in person.

**Provider compensation:** The telehealth coverage law requires parity for enrollee cost sharing, but it is silent about provider compensation. There are many factors that go into a fair, reasonable, and equitable charge. Strict parity could be appropriate in some cases but not others, and the Legislature did not impose any uniform formula or methodology.

During the COVID-19 health insurance emergency, when it was necessary to substitute telehealth services for many in-person services, the Superintendent ordered payment parity for telehealth as a temporary measure. However, that order expired when the state of insurance emergency terminated on July 31, 2021.

**Network Adequacy:** Finally, the recent legislation adds a requirement that a health plan’s network adequacy must be determined on the basis of the availability of in-person services. Telehealth can be a valuable supplement to in-person health care, but at this time, Maine law does not permit carriers to use it to replace the option to access health care in an in-person setting.



## MARYLAND

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Maryland



**Authority: Md. Code, Ins. § 15-139; Md. Code Regs. 31.10.45.02(B)(15)**

## **Md. Code, Ins. § 15-139**

*Health care services delivered through telehealth*

### **Telehealth defined**

a)(1) In this section, “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.

(2) “Telehealth” includes from July 1, 2021, to June 30, 2025, both inclusive, an audio-only telephone conversation between a health care provider and a patient that results in the delivery of a billable, covered health care service.

(3) “Telehealth” does not include:

(i) except as provided in paragraph (2) of this subsection, an audio-only telephone conversation between a health care provider and a patient;

(ii) an electronic mail message between a health care provider and a patient; or

(iii) a facsimile transmission between a health care provider and a patient.

### **Application of section**

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

### **Coverage for health care services delivered through telehealth**

(c)(1) An entity subject to this section:

(i) shall provide coverage under a health insurance

policy or contract for health care services appropriately delivered through telehealth regardless of the location of the patient at the time the telehealth services are provided;

(ii) may not exclude from coverage a health care service solely because it is provided through telehealth and is not provided through an in-person consultation or contact between a health care provider and a patient; and

(iii) may not exclude from coverage or deny coverage for a behavioral health care service that is a covered benefit under a health insurance policy or contract when provided in person solely because the behavioral health care service may also be provided through a covered telehealth benefit.

(2) The health care services appropriately delivered through telehealth shall include counseling and treatment for substance use disorders and mental health conditions.

### **Reimbursement to health care provider for services delivered through telehealth**

(d) (1) Subject to paragraph (2) of this subsection, an entity subject to this section:

(i) shall reimburse a health care provider for the diagnosis, consultation, and treatment of an insured patient for a health care service covered under a health insurance policy or contract that can be appropriately provided through telehealth;

(ii) is not required to:

(1) reimburse a health care provider for a health care service delivered in person or through telehealth that is not a covered benefit under the health insurance policy or contract; or

(2) reimburse a health care provider who is not a covered provider under the health insurance policy or contract; and

(iii)(1) may impose a deductible, copayment, or coinsurance amount on benefits for health care services that are delivered either through an in-person consultation or through telehealth;





(2) may impose an annual dollar maximum as permitted by federal law; and

(3) may not impose a lifetime dollar maximum.

(2)(i) From July 1, 2021, to June 30, 2025, both inclusive, when a health care service is appropriately provided through telehealth, an entity subject to this section shall provide reimbursement in accordance with paragraph (1)(i) of this subsection on the same basis and at the same rate as if the health care service were delivered by the health care provider in person.

(ii) The reimbursement required under subparagraph (i) of this paragraph does not include:

1. clinic facility fees unless the health care service is provided by a health care provider not authorized to bill a professional fee separately for the health care service; or

2. any room and board fees.

(iii) This paragraph may not be construed to supersede the authority of the Health Services Cost Review Commission to set the appropriate rates for hospitals, including setting the hospital facility fee for hospital-provided telehealth.

#### **Requirement for third-party vendor prohibited**

(e) Subject to subsection (d)(1)(ii) of this section, an entity subject to this section may not impose as a condition of reimbursement of a covered health care

service delivered through telehealth that the health care service be provided by a third-party vendor designated by the entity.

#### **Utilization review to determine appropriateness of health care service**

(f) Subject to subsection (d)(1)(ii) of this section, an entity subject to this section may not impose as a condition of reimbursement of a covered health care service delivered through telehealth that the health care service be provided by a third-party vendor designated by the entity.

#### **Policies or contracts not to distinguish between patients in rural or urban locations**

(g) A health insurance policy or contract may not distinguish between patients in rural or urban locations in providing coverage under the policy or contract for health care services delivered through telehealth.

#### **Decision by entity not to provide coverage for telehealth**

(h) A decision by an entity subject to this section not to provide coverage for telehealth in accordance with this section constitutes an adverse decision, as defined in § 15-10A-01 of this title, if the decision is based on a finding that telehealth is not medically necessary, appropriate, or efficient.

# MASSACHUSETTS

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes No Limited N/A

# Massachusetts



**Authorities: M.G.L.A. 175 § 47MM , 176A § 38 , 176B § 25 , 176G § 33 , 176I § 13 , 32A § 30**

## **M.G.L.A. 175 § 47MM<sup>6</sup>**

*Coverage for health care services delivered via telehealth*

(a) For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

“Behavioral health services”, care and services for the evaluation, diagnosis, treatment or management of patients with mental health, developmental or substance use disorders.

“Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including, but not limited to: (i) interactive audio-video technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of a patient’s physical health, oral health, mental health or substance use disorder condition.

(b) An individual policy of accident and sickness insurance issued under section 108 that provides hospital expense and surgical expense insurance and any group blanket or general policy of accident and sickness insurance issued under section 110 that provides hospital expense and surgical expense insurance that is issued or renewed within or without the commonwealth shall provide coverage for health care services delivered via telehealth by a contracted health care provider if: (i) the health care services are covered by way of in-person consultation or delivery; and (ii) the health care services may be appropriately provided through the use of telehealth; provided,

however, that an insurer shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request. Coverage shall not be limited to services delivered by third-party providers.

(c) Coverage for telehealth services may include utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service; provided, however, that the determination shall be made in the same manner as if the service was delivered in-person. A policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within or without the commonwealth shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan or reimburse a health care provider not contracted under the plan except as provided for under subclause (i) of clause (4) of the second sentence of subsection (a) of section 6 of chapter 176O.

(d) A health care provider shall not be required to document a barrier to an in-person visit nor shall the type of setting where telehealth services are provided be limited for health care services provided via telehealth; provided, however, that a patient may decline receiving services via telehealth in order to receive in-person services.

(e) A policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth that provides coverage for telehealth services may include a deductible, copayment or coinsurance requirement for a health care service

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<sup>6</sup> See also M.G.L.A. 176A § 38 (applying the same coverage provisions to a subscriber and a nonprofit hospital service corporation under an individual or group hospital service plan); see also M.G.L.A. 176B § 25 (applying the same coverage provisions to a contract between a subscriber and a medical service corporation); see also M.G.L.A. 176G § 33 (applying the same coverage provisions to a contract between a member and a health maintenance organization); see also M.G.L.A. 176I § 13 (applying the same coverage provisions to a preferred provider organization contract); see also M.G.L.A. 32A § 30 (applying the same coverage provisions to contributory group general or blanket insurance contracts for government employees).





provided via telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. The rate of payment for telehealth services provided via interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities.

(f) Coverage that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account for the provision of telehealth services to set the global payment amount.

(g) Insurance companies organized under this chapter shall ensure that the rate of payment for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone shall be no less than the rate of payment for the same behavioral health service delivered via in-person methods; provided, that this subsection shall apply to providers of behavioral health services covered as required under subclause (i) of clause (4) of the second sentence of subsection (a) of section 6 of chapter 1760.

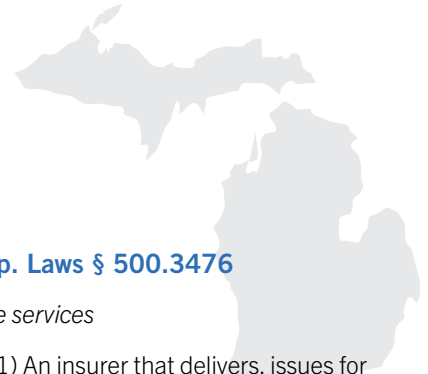
(h) Health care services provided via telehealth shall conform to the standards of care applicable to the telehealth provider's profession and specialty. Such services shall also conform to applicable federal and state health information privacy and security standards as well as standards for informed consent.

## MICHIGAN

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Michigan



**Authorities: Mich. Comp. Laws §§ 500.3476, 550.1401k**

## **Mich. Comp. Laws § 550.1401k**

### *Telemedicine services*

Sec. 401k. (1) A group or nongroup health care corporation certificate must not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the health care corporation. Telemedicine services 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. Telemedicine services are subject to all terms and conditions of the certificate agreed upon between the certificate holder and the health care corporation, including, but not limited to, required copayments, coinsurances, deductibles and approved amounts.

(2) As used in this section, “telemedicine” means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine under this section, the health care professional must be able to examine the patient via a health insurance portability and accountability act of 1996, Public Law 104-91 compliant, secure interactive audio or video, or both, telecommunications system, or through the use of store and forward online messaging.

(3) This section applies to a certificate issued or renewed after December 31, 2012.

## **Mich. Comp. Laws § 500.3476**

### *Telemedicine services*

Sec. 3476. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy 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 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. Telemedicine services are subject to all terms and conditions of the health insurance policy agreed upon between the policy holder and the insurer, including, but not limited to, required copayments, coinsurances, deductibles and approved amounts.

(2) As used in this section:

(a) After December 31, 2017, “insurer” includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

(b) “Telemedicine” means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine under this section, the health care professional must be able to examine the patient via a health insurance portability and accountability act of 1996, Public Law 104-191 compliant, secure interactive audio or video, or both, telecommunications system, or through the use of store and forward online messaging.

## MINNESOTA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A



# Minnesota

**Authorities:** Minn. Stat. § 62A.673

## **Minn. Stat. Ann. § 62A.673**

*Coverage of services provided through telehealth*

**Subdivision 1.** Citation. This section may be cited as the “Minnesota Telehealth Act.”

**Subd. 2.** Definitions. (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) “Distant site” means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.

(c) “Health care provider” means a health care professional who is licensed or registered by the state to perform health care services within the provider’s scope of practice and in accordance with state law. A health care provider includes a mental health professional under section 245I.04, subdivision 2; a mental health practitioner under section 245I.04, subdivision 4; a clinical trainee under section 245I.04, subdivision 6; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

(d) “Health carrier” has the meaning given in section 62A.011, subdivision 2.

(e) “Health plan” has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

(f) “Originating site” means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth. For purposes of store-and-forward technology, the originating site also means the location at which a health care provider transfers or transmits information to the distant site.

(g) “Store-and-forward technology” means the asynchronous electronic transfer or transmission of a patient’s medical information or data from an originating site to a distant site for the purposes of

diagnostic and therapeutic assistance in the care of a patient.

(h) “Telehealth” means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient’s health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Until July 1, 2025, telehealth also includes audio-only communication between a health care provider and a patient in accordance with subdivision 6, paragraph (b). Telehealth does not include communication between health care providers that consists solely of a telephone conversation, email, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an email or facsimile transmission. Telehealth does not include telemonitoring services as defined in paragraph (i).

(i) “Telemonitoring services” means the remote monitoring of clinical data related to the enrollee’s vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect an enrollee’s health-related data for the purpose of assisting a health care provider in assessing and monitoring the enrollee’s medical condition or status.

**Subd. 3.** Coverage of telehealth. (a) A health plan sold, issued, or renewed by a health carrier in Minnesota must (1) cover benefits delivered through telehealth in the same manner as any other benefits covered under the health plan, and (2) comply with this section.

(b) Coverage for services delivered through telehealth must not be limited on the basis of geography, location, or distance for travel subject to the health care provider network available to the enrollee through the enrollee’s health plan.

(c) A health carrier must not create a separate provider network to deliver services through telehealth that does not include network providers who provide in-person care to patients for the same service or require an enrollee to use a specific provider within the network to receive services through telehealth.

(d) A health carrier may require a deductible, co-payment, or coinsurance payment for a health care service provided through telehealth, provided that the deductible, co-payment, or coinsurance payment is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable for the same service provided through in-person contact.

(e) Nothing in this section:

(1) requires a health carrier to provide coverage for services that are not medically necessary or are not covered under the enrollee's health plan; or

(2) prohibits a health carrier from:

(i) establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service through telehealth for which the health carrier does not already reimburse other health care providers for delivering the service through telehealth;

(ii) establishing reasonable medical management techniques, provided the criteria or techniques are not unduly burdensome or unreasonable for the particular service; or

(iii) requiring documentation or billing practices designed to protect the health carrier or patient from fraudulent claims, provided the practices are not unduly burdensome or unreasonable for the particular service.

(f) Nothing in this section requires the use of telehealth when a health care provider determines that the delivery of a health care service through telehealth is not appropriate or when an enrollee chooses not to receive a health care service through telehealth.

**Subd. 4.** Parity between telehealth and in-person services. (a) A health carrier must not restrict or deny coverage of a health care service that is covered under a health plan solely:

(1) because the health care service provided by the health care provider through telehealth is not provided through in-person contact; or

(2) based on the communication technology or application used to deliver the health care service through telehealth, provided the technology or application complies with this section and is appropriate for the particular service.

(b) Prior authorization may be required for health care services delivered through telehealth only if prior authorization is required before the delivery of the same service through in-person contact.

(c) A health carrier may require a utilization review for services delivered through telehealth, provided the utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for the same services delivered through in-person contact.

(d) A health carrier or health care provider shall not require an enrollee to pay a fee to download a specific communication technology or application.

**Subd. 5.** Reimbursement for services delivered through telehealth. (a) A health carrier must reimburse the health care provider for services delivered through telehealth on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered by the health care provider through in-person contact.

(b) A health carrier must not deny or limit reimbursement based solely on a health care provider delivering the service or consultation through telehealth instead of through in-person contact.

(c) A health carrier must not deny or limit reimbursement based solely on the technology and equipment used by the health care provider to deliver the health care service or consultation through telehealth, provided the technology and equipment used by the provider meets the requirements of this section and is appropriate for the particular service.

(d) Nothing in this subdivision prohibits a health carrier and health care provider from entering into a contract that includes a value-based reimbursement arrangement for the delivery of covered services that may include services delivered through telehealth, and such an arrangement shall not be considered a violation of this subdivision.

**Subd. 6.** Telehealth equipment. (a) A health carrier must not require a health care provider to use specific telecommunications technology and equipment as a condition of coverage under this section, provided the

health care provider uses telecommunications technology and equipment that complies with current industry interoperable standards and complies with standards required under the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and regulations promulgated under that Act, unless authorized under this section.

(b) A health carrier must provide coverage for health care services delivered through telehealth by means of the use of audio-only communication if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication. Substance use disorder treatment services and mental health care services delivered through telehealth by means of audio-only communication may be covered without a scheduled appointment if the communication was initiated by the enrollee while in an emergency or crisis situation and a scheduled appointment was not possible due to the need of an immediate response. This paragraph expires July 1, 2023.

**Subd. 7.** Telemonitoring services. A health carrier must provide coverage for telemonitoring services if:

- (1) the telemonitoring service is medically appropriate based on the enrollee's medical condition or status;
- (2) the enrollee is cognitively and physically capable of operating the monitoring device or equipment, or the enrollee has a caregiver who is willing and able to assist with the monitoring device or equipment; and
- (3) the enrollee resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

Subd. 8. Exception. This section does not apply to coverage provided to state public health care program enrollees under chapter 256B or 256L.

## MISSISSIPPI

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Mississippi

**Authorities: Miss. Code §§ 83-9-351, 83-9-353**

## **Miss. Code § 83-9-351**

### *Telemedicine services coverage*

(1) As used in this section:

(a) “Employee benefit plan” means any plan, fund or program established or maintained by an employer or by an employee organization, or both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, hospital care or other benefits.

(b) “Health insurance plan” means any health insurance policy or health benefit plan offered by a health insurer, and includes the State and School Employees Health Insurance Plan and any other public health care assistance program offered or administered by the state or any political subdivision or instrumentality of the state. The term does not include policies or plans providing coverage for specified disease or other limited benefit coverage.

(c) “Health insurer” means any health insurance company, nonprofit hospital and medical service corporation, health maintenance organization, preferred provider organization, managed care organization, pharmacy benefit manager, and, to the extent permitted under federal law, any administrator of an insured, self-insured or publicly funded health care benefit plan offered by public and private entities, and other parties that are by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(d) “Telemedicine” means the delivery of health care services such as diagnosis, consultation or treatment through the use of HIPAA-compliant telecommunication systems, including information, electronic and communication technologies, remote patient monitoring services and store-and-forward telemedicine services. Telemedicine, other than remote patient monitoring services and store-and-forward telemedicine services, must be “real-time” audio visual capable. The Commissioner of Insurance may adopt

rules and regulations addressing when “real-time” audio interactions without visual are allowable, which must be medically appropriate for the corresponding health care services being delivered.

(2) 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. All health insurance and employee benefit plans in this state must reimburse providers who are out-of-network for telemedicine services under the same reimbursement policies applicable to other out-of-network providers of healthcare services.

(3) A health insurance or employee benefit plan may charge a deductible, copayment or coinsurance for a health care service provided through telemedicine so long as it does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

(4) Nothing in this section shall be construed to prohibit a health insurance or employee benefit plan from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered person’s policy.

(5) In a claim for the services provided, the appropriate procedure code for the covered services shall be included with the appropriate modifier indicating interactive communication was used. Health insurance and employee benefit plans shall reimburse providers for telemedicine services using the proper medical codes.

(6) The originating site is eligible to receive a facility fee, but facility fees are not payable to the distant site. Health insurance and employee benefit plans shall not limit coverage to provider-to-provider consultations only. Patients in a patient-to-provider consultation shall not be entitled to receive a facility fee.

(7) Nothing in this section shall be interpreted to create new standards of care for health care services delivered through the use of telemedicine.

(8) The Commissioner of Insurance may adopt rules and regulations for the administration of this chapter.

(9) This section shall stand repealed from and after July 1, 2025.

**Miss. Code § 83-9-353**

*Requirement to provide coverage and reimburse for telemedicine and remote patient monitoring services*

(1) As used in this section:

(a) “Employee benefit plan” means any plan, fund or program established or maintained by an employer or by an employee organization, or both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, hospital care or other benefits..

(b) “Health insurance plan” means any health insurance policy or health benefit plan offered by a health insurer, and includes the State and School Employees Health Insurance Plan and any other public health care assistance program offered or administered by the state or any political subdivision or instrumentality of the state. The term does not include policies or plans providing coverage for specified disease or other limited benefit coverage.

(c) “Health insurer” means any health insurance company, nonprofit hospital and medical service corporation, health maintenance organization, preferred provider organization, managed care organization, pharmacy benefit manager, and, to the extent permitted under federal law, any administrator of an insured, self-insured or publicly funded health care benefit plan offered by public and private entities, and other parties that are by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(d) “Store-and-forward telemedicine services” means the use of asynchronous computer-based communication between a patient and a consulting provider or a referring health care provider and a medical specialist at a distant site for the purpose of diagnostic and therapeutic assistance in the care of patients who otherwise have no access to specialty care. Store-and-forward telemedicine services involve the transferring of medical data from one (1) 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.

(e) “Remote patient monitoring services” means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including:

(i) Monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry and other condition-specific data, such as blood glucose;

(ii) Medication adherence monitoring; and

(iii) Interactive video conferencing with or without digital image upload as needed.

(f) “Medication adherence management services” means the monitoring of a patient’s conformance with the clinician’s medication plan with respect to timing, dosing and frequency of medication-taking through electronic transmission of data in a home telemonitoring program.

(2) Store-and-forward telemedicine services allow a health care provider trained and licensed in his or her given specialty to review forwarded images and patient history in order to provide diagnostic and therapeutic assistance in the care of the patient without the patient being present in real time. Treatment recommendations made via electronic means shall be held to the same standards of appropriate practice as those in traditional provider-patient setting.

(3) Any patient receiving medical care by store-and-forward telemedicine services shall be notified of the right to receive interactive communication with the distant specialist health care provider and shall receive an interactive communication with the distant specialist upon request. If requested, communication with the distant specialist may occur at the time of the consultation or within thirty (30) days of the patient’s notification of the request of the consultation. Telemedicine networks unable to offer the interactive consultation shall not be reimbursed for store-and-forward telemedicine services.

(4) Remote patient monitoring services aim to allow more people to remain at home or in other residential settings and to improve the quality and cost of their care, including prevention of more costly care. Remote patient monitoring services via telehealth aim to coordinate primary, acute, behavioral and long-term social service needs for high-need, high-cost patients. Specific patient criteria must be met in order for reimbursement to occur.

(5) Qualifying patients for remote patient monitoring services must meet all the following criteria:

(a) Be diagnosed, in the last eighteen (18) months, with one or more chronic conditions, as defined by the Centers for Medicare and Medicaid Services (CMS), which include, but are not limited to, sickle cell, mental health, asthma, diabetes and heart disease; and

(c) The patient's health care provider recommends disease management services via remote patient monitoring.

(6) A remote patient monitoring prior authorization request form may be required for approval of telemonitoring services. If prior authorization is required, the request form must include the following:

(a) An order for home telemonitoring services, signed and dated by the prescribing physician;

(b) A plan of care, signed and dated by the prescribing physician, that includes telemonitoring transmission frequency and duration of monitoring requested;

(c) The client's diagnosis and risk factors that qualify the client for home telemonitoring services;

(d) Attestation that the client is sufficiently cognitively intact and able to operate the equipment or has a willing and able person to assist in completing electronic transmission of data; and

(e) Attestation that the client is not receiving duplicative services via disease management services.

(7) The entity that will provide the remote monitoring must be a Mississippi-based entity and have protocols in place to address all of the following:

(a) Authentication and authorization of users;

(b) A mechanism for monitoring, tracking and responding to changes in a client's clinical condition;

(c) A standard of acceptable and unacceptable parameters for client's clinical parameters, which can be adjusted based on the client's condition;

(d) How monitoring staff will respond to abnormal parameters for client's vital signs, symptoms and/or lab results;

(e) The monitoring, tracking and responding to changes in client's clinical condition;

(f) The process for notifying the prescribing physician

for significant changes in the client's clinical signs and symptoms;

(g) The prevention of unauthorized access to the system or information;

(h) System security, including the integrity of information that is collected, program integrity and system integrity;

(i) Information storage, maintenance and transmission;

(j) Synchronization and verification of patient profile data; and

(k) Notification of the client's discharge from remote patient monitoring services or the de-installation of the remote patient monitoring unit.

(8) The telemonitoring equipment must:

(a) Be capable of monitoring any data parameters in the plan of care; and

(b) Be a FDA Class II hospital-grade medical device.

(9) Monitoring of the client's data shall not be duplicated by another provider.

(10) To receive payment for the delivery of remote patient monitoring services via telehealth, the service must involve:

(a) An assessment, problem identification, and evaluation that includes:

(i) Assessment and monitoring of clinical data including, but not limited to, appropriate vital signs, pain levels and other biometric measures specified in the plan of care, and also includes assessment of response to previous changes in the plan of care; and

(ii) Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care.

(b) Implementation of a management plan through one or more of the following:

(i) Teaching regarding medication management as appropriate based on the telemedicine findings for that encounter;

(ii) Teaching regarding other interventions as appropriate to both the patient and the caregiver;

(iii) Management and evaluation of the plan of care including changes in visit frequency or addition of other skilled services;





(iv) Coordination of care with the ordering health care provider regarding telemedicine findings;

(v) Coordination and referral to other medical providers as needed; and

(vi) Referral for an in-person visit or the emergency room as needed.

(11) The telemedicine equipment and network used for remote patient monitoring services should meet the following requirements:

(a) Comply with applicable standards of the United States Food and Drug Administration;

(b) Telehealth equipment be maintained in good repair and free from safety hazards;

(c) Telehealth equipment be new or sanitized before installation in the patient's home setting;

(d) Accommodate non-English language options; and

(e) Have 24/7 technical and clinical support services available for the patient user.

(12) 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. Store-and-forward telemedicine services shall be reimbursed to the same extent that the services would be covered if they were provided through in-person consultation.

(13) Remote patient monitoring services shall include reimbursement for a daily monitoring rate at a minimum of Ten Dollars (\$10.00) per day each month and Sixteen Dollars (\$16.00) per day when medication adherence management services are included, not to exceed thirty-one (31) days per month. These reimbursement rates are only eligible to Mississippi-based telehealth programs affiliated with a Mississippi health care facility.

(14) A one-time telehealth installation/training fee for remote patient monitoring services will also be reimbursed at a minimum rate of Fifty Dollars (\$50.00) per patient, with a maximum of two (2) installation/training fees/calendar year. These reimbursement rates are only eligible to Mississippi-based telehealth

programs affiliated with a Mississippi health care facility.

(15) No geographic restrictions shall be placed on the delivery of telemedicine services in the home setting other than requiring the patient reside within the State of Mississippi.

(16) Health care providers seeking reimbursement for store-and-forward telemedicine services must be licensed Mississippi providers that are affiliated with an established Mississippi health care facility in order to qualify for reimbursement of telemedicine services in the state. If a service is not available in Mississippi, then a health insurance or employee benefit plan may decide to allow a non-Mississippi-based provider who is licensed to practice in Mississippi reimbursement for those services.

(17) A health insurance or employee benefit plan may charge a deductible, copayment or coinsurance for a health care service provided through store-and-forward telemedicine services or remote patient monitoring services so long as it does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

(18) A health insurance or employee benefit plan may limit coverage to health care providers in a telemedicine network approved by the plan.

(19) Nothing in this section shall be construed to prohibit a health insurance or employee benefit plan from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered person's policy.

(20) In a claim for the services provided, the appropriate procedure code for the covered service shall be included with the appropriate modifier indicating telemedicine services were used. A "GQ" modifier is required for asynchronous telemedicine services such as store-and-forward and remote patient monitoring.

(21) The originating site is eligible to receive a facility fee, but facility fees are not payable to the distant site.

## MISSOURI

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Missouri



**Authority: Mo. Stat. § 376.1900**

## **Mo. Stat. § 376.1900**

*Definitions—reimbursement for telehealth services, when*

1. As used in this section, the following terms shall mean:

(1) “Electronic visit,” or “e-visit,” an online electronic medical evaluation and management service completed using a secured web-based or similar electronic-based communications network for a single patient encounter. An electronic visit shall be initiated by a patient or by the guardian of a patient with the health care provider, be completed using a federal Health Insurance Portability and Accountability Act (HIPAA)-compliant online connection, and include a permanent record of the electronic visit;

(2) “Health benefit plan” shall have the same meaning ascribed to it in section 376.1350;

(3) “Health care provider” shall have the same meaning ascribed to it in section 376.1350;

(4) “Health care service”, a service for the diagnosis, prevention, treatment, cure or relief of a physical or mental health condition, illness, injury or disease;

(5) “Health carrier” shall have the same meaning ascribed to it in section 376.1350;

(6) “Telehealth” shall have the same meaning ascribed to it in section 208.670 [Mo. Stat. § 208.670 (“Telehealth”, the same meaning as such term is defined in section 191.1145); Mo. Stat. § 191.1145 (“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.)].

2. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2014, 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.

3. 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.

4. 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.

5. A health care service provided through telehealth shall not be subject to any greater deductible, copayment or coinsurance amount than would be applicable if the same health care service was provided through face-to-face diagnosis, consultation or treatment.

6. A health carrier shall not impose upon any person receiving benefits under this section any copayment, coinsurance, or deductible amount, or any policy year, calendar year, lifetime or other durational benefit limitation or maximum for benefits or services that is not equally imposed upon all terms and services covered under the policy, contract or health benefit plan.





7. Nothing in this section shall preclude a health carrier from undertaking utilization review to determine the appropriateness of telehealth as a means of delivering a health care service, provided that the determinations shall be made in the same manner as those regarding the same service when it is delivered in person.

8. 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.

9. Nothing in this section shall be construed to require a health care provider to be physically present with a patient where the patient is located unless the health care provider who is providing health care services by means of telehealth determines that the presence of a health care provider is necessary.

10. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies of six months' or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

## MONTANA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Montana



**Authority: Mont. Code § 33-22-138**

## **Mont. Code § 33-22-138**

### *Coverage for telehealth services*

- (1) Each group or individual policy, certificate of disability insurance, subscriber contract, membership contract or health care services agreement that provides coverage for health care services must provide coverage for health care services provided by a health care provider or health care facility by means of telehealth if the services are otherwise covered by the policy, certificate, contract or agreement.
- (2) A policy, certificate, contract, or agreement may not:
  - (a) impose restrictions involving:
    - (i) the site at which the patient is physically located and receiving health care services by means of telehealth; or
    - (ii) the site at which the health care provider is physically located and providing the services by means of telehealth; or
  - (b) distinguish between telehealth services provided to patients in rural locations and telehealth services provided to patients in urban locations.
- (3) Coverage under this section must be equivalent to the coverage for services that are provided in person by a health care provider or health care facility.
- (4) Nothing in this section may be construed to require:
  - (a) a health insurance issuer to provide coverage for services that are not medically necessary, subject to the terms and conditions of the insured's policy;
  - (b) coverage of an otherwise noncovered benefit;
  - (c) a health care provider to be physically present with a patient at the site where the patient is located unless the health care provider who is providing health care services by means of telehealth determines that the presence of a health care provider is necessary; or
  - (d) except as provided in 50–46–310 or as provided in Title 37 and related administrative rules, a patient to

have a previously established patient-provider relationship with a specific health care provider in order to receive health care services by means of telehealth.

- (5) Coverage under this section may be subject to deductibles, coinsurance and copayment provisions. Special deductible, coinsurance, copayment or other limitations that are not generally applicable to other medical services covered under the plan may not be imposed on the coverage for services provided by means of telehealth.
- (6) This section does not apply to disability income, hospital indemnity, Medicare supplement, specified disease or long-term care policies.
- (7) The commissioner may adopt rules necessary to implement the provisions of this section.
- (8) For the purposes of this section, the following definitions apply:
  - (a) "Health care facility" means a critical access hospital, hospice, hospital, long-term care facility, mental health center, outpatient center for primary care or outpatient center for surgical services licensed pursuant to Title 50, chapter 5.
  - (b) "Health care provider" means an individual:
    - (i) licensed pursuant to Title 37, chapter 3, 6, 7, 10, 11, 15, 17, 20, 22, 23, 24, 25, 26 or 35;
    - (ii) licensed pursuant to Title 37, chapter 8, to practice as a registered professional nurse or as an advanced practice registered nurse;
    - (iii) certified by the American board of genetic counseling as a genetic counselor; or
    - (iv) certified by the national certification board for diabetes educators as a diabetes educator.
  - (c)(i) "Telehealth" means the use of audio, video or other telecommunications technology or media, including audio-only communication, that is:
    - (A) used by a health care provider or health care facility to deliver health care services; and







(B) delivered over a secure connection that complies with state and federal privacy laws.

(ii) (ii) The term does not include delivery of health care services by means of facsimile machines or electronic messaging alone. The use of facsimile and electronic message is not precluded if used in conjunction with other audio, video, or telecommunications technology or media.

(iii) For physicians providing written certification of a debilitating medical condition pursuant to 50–46–310, the term does not include audio-only communication unless the physician has previously established a physician-patient relationship through an in-person encounter.

## NEBRASKA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Nebraska



**Authorities: Neb. Rev. Stat. §§ 44-7,107; 44-312**

## **Neb. Rev. Stat. § 44-7,107**

*Telehealth; asynchronous review by dermatologist; coverage*

(1) For purposes of this section:

(a) Asynchronous review means 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;

(b) Dermatologist means a board-certified physician who is trained to evaluate and treat individuals with benign and malignant disorders of the skin, hair, nails, and adjacent mucous membranes with a specialization in the diagnosis and treatment of skin cancers, melanomas, moles, and other tumors of the skin along with surgical techniques used in dermatology and interpretation of skin biopsies; and

(c) Telehealth has the same meaning as in section 44-312.

(2) Any insurer offering (a) any individual or group sickness and accident insurance policy, certificate, or subscriber contract delivered, issued for delivery, or renewed in this state, (b) any hospital, medical, or surgical expense-incurred policy, or (c) any self-funded employee benefit plan to the extent not preempted by federal law, shall not exclude, in any policy, certificate, contract, or plan offered or renewed on or after August 24, 2017, a service from coverage solely because the service is delivered through telehealth, including services originating from any location where the patient is located, and is not provided through in-person consultation or contact between a licensed health care provider and a patient.

(3)(a) Any insurer offering any policy, certificate, contract, or plan described in subsection (2) of this section for which coverage of benefits begins on or after January 1, 2021, shall not exclude from coverage telehealth services provided by a dermatologist solely because the service is delivered asynchronously.

(b) An insurer shall reimburse a health care provider for asynchronous review by a dermatologist delivered through telehealth at a rate negotiated between the provider and the insurer.

(c) It is not a violation of this subsection for an insurer to include a deductible, copayment, or coinsurance requirement for a health care service provided through telehealth if such costs do not exceed those included for the same services provided through in-person contact.

(4) Nothing in this section shall be construed to require an insurer to provide coverage for services that are not medically necessary.

(5) This section does not apply to any policy, certificate, contract, or plan that provides coverage for a specified disease or other limited-benefit coverage.

## **Neb. Rev. Stat. § 44-312**

*Telehealth and telemonitoring services covered under policy, certificate, contract, or plan; insurer; duties; reimbursement rate; requirements*

(1) For purposes of this section:

(a)(i) 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.

(ii) Telehealth includes (A) services originating from a patient's home or any other location where such patient is located, (B) 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 (C) telemonitoring.

(iii) Telehealth also includes audio-only services for the delivery of individual behavioral health services for an established patient, when appropriate, or crisis management and intervention for an established patient as allowed by federal law; and

(b) 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.

(2) Any insurer offering (a) any individual or group sickness and accident insurance policy, certificate, or



subscriber contract delivered, issued for delivery, or renewed in this state, (b) any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, or (c) any self-funded employee benefit plan to the extent not preempted by federal law, shall provide upon request to 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.

(3) The description shall include:

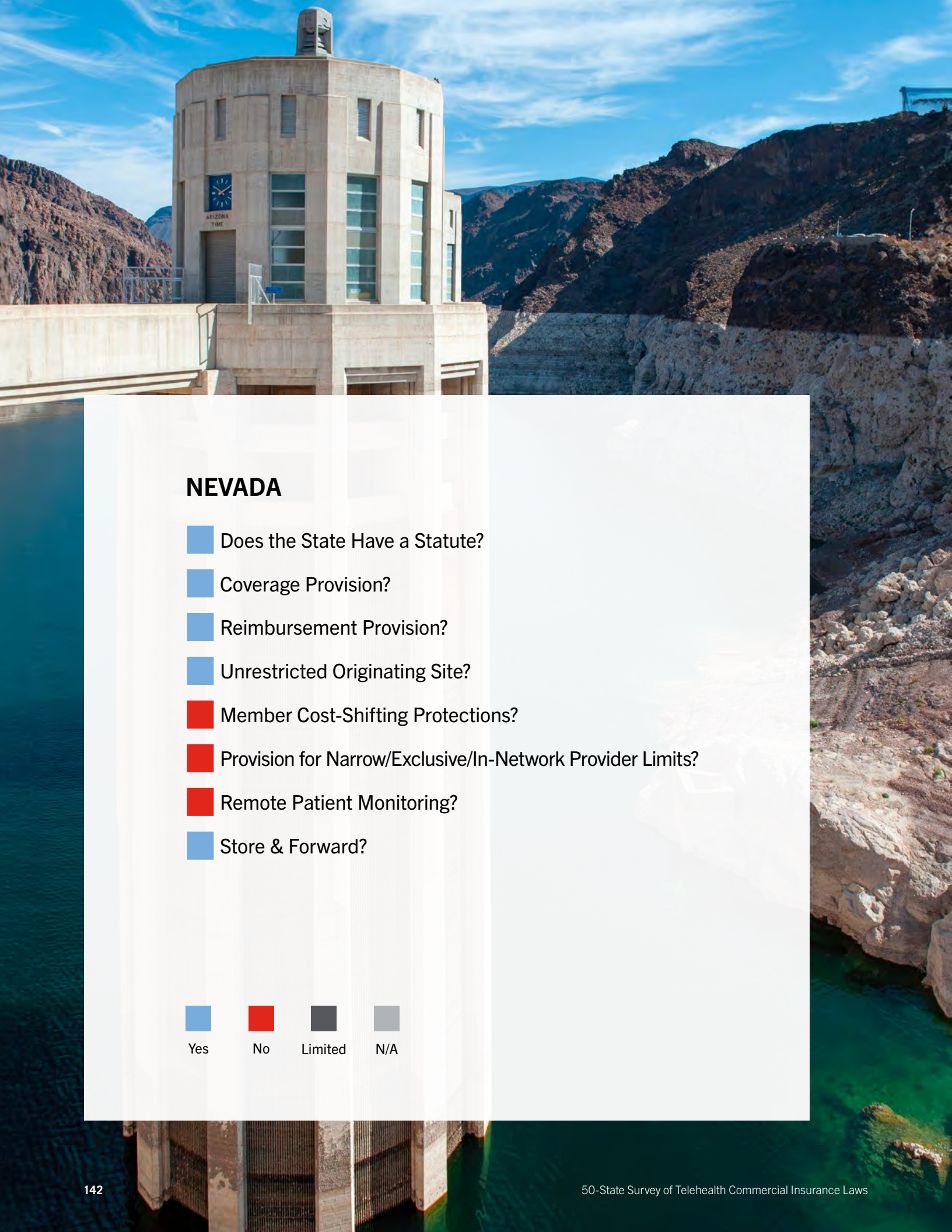
(a) A description of services included in telehealth and telemonitoring coverage, including, but not limited to, any coverage for transmission costs;

(b) Exclusions or limitations for telehealth and

telemonitoring coverage, including, but not limited to, any limitation on coverage for transmission costs; and

(c) Requirements for the licensing status of health care providers providing telehealth and telemonitoring services.

(4) Except as otherwise provided in section 44-793, the reimbursement rate for any telehealth service shall, at a minimum, be the same as a comparable in-person health care service if the licensed provider providing the telehealth service also provides in-person health care services at a physical location in Nebraska or is employed by or holds medical staff privileges at a licensed facility in Nebraska and such facility provides in-person health care services in Nebraska.



## NEVADA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Nevada

**Authorities: Nev. Rev. Stat. § 689A.0463; Nev. Rev. Stat. § 689B.0369; Nev. Rev. Stat. § 689C.195; Nev. Rev. Stat. § 616C.730; Nev. Rev. Stat. § 695A.265; Nev. Rev. Stat. § 695B.1904; Nev. Rev. Stat. § 695C.1708; Nev. Rev. Stat. § 695D.216; Nev. Rev. Stat. § 695G.162; Nev. Rev. Stat. § 629.515.**

## **Nev. Rev. Stat. § 689A.0463**

*Coverage for services provided through telehealth; required to same extent and in same amount as through provided in person or by other means; exception; prohibited acts*

1. A policy of health insurance must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.
2. A policy of health insurance must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means:
  - (a) If the services:
    - (1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic; and
    - (2) Except for services described in paragraph (b), are not provided through audio-only interaction; or
  - (b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.
3. An insurer shall not:
  - (a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;
  - (b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage

described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A policy of health insurance must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A policy of health insurance may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. The provisions of this section do not require an insurer to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) 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.

6. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

7. As used in this section:

(a) "Distant site" has the meaning ascribed to it in NRS 629.515.

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) "Originating site" has the meaning ascribed to it in NRS 629.515.

(d) "Provider of health care" has the meaning ascribed to it in NRS 439.820.

(e) "Rural health clinic" has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

(f) "Telehealth" has the meaning ascribed to it in NRS 629.515.

#### **Nev. Rev. Stat. § 689B.0369**

*Required provision concerning coverage for services provided through telehealth to same extent and in same amount as though provided in person or by other means; exception; prohibited acts*

1. A policy of group or blanket health insurance must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.

2. A policy of group or blanket health insurance must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means:

(a) If the services:

(1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic; and

(2) Except for services described in paragraph (b), are not provided through audio-only interaction; or

(b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.

3. An insurer shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any

additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A policy of group or blanket health insurance must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for that service when provided in person. A policy of group or blanket health insurance may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. The provisions of this section do not require an insurer to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) 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.

6. A policy of group or blanket health insurance subject



to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

7. As used in this section:

(a) “Distant site” has the meaning ascribed to it in NRS 629.515.

(b) “Federally-qualified health center” has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) “Originating site” has the meaning ascribed to it in NRS 629.515.

(d) “Provider of health care” has the meaning ascribed to it in NRS 439.820.

(e) “Rural health clinic” has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

(f) “Telehealth” has the meaning ascribed to it in NRS 629.515.

### **Nev. Rev. Stat. § 689C.195**

*Coverage for services provided through telehealth required to same extent and in same amount as though provided in person or by other means; exception; prohibited acts*

1. A health benefit plan must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.

2. A health benefit plan must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means:

(a) If the services:

(1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic;

(2) Except for services described in paragraph (b), are not provided through audio-only interaction; or

(b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.

3. A carrier shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services

through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A health benefit plan must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A health benefit plan may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. The provisions of this section do not require a carrier to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the carrier is not otherwise required by law to do so.

6. A plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage

required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

7. As used in this section:

(a) “Distant site” has the meaning ascribed to it in NRS 629.515.

(b) “Federally-qualified health center” has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) “Originating site” has the meaning ascribed to it in NRS 629.515.

(d) “Provider of health care” has the meaning ascribed to it in NRS 439.820.

(e) “Rural health clinic” has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

(f) “Telehealth” has the meaning ascribed to it in NRS 629.515.

### **Nev. Rev. Stat. § 616C.730**

*Policy of insurance required to include coverage for services provided through telehealth; limitations*

1. Every policy of insurance issued pursuant to chapters 616A to 617, inclusive, of NRS must include coverage for services provided to an employee through telehealth to the same extent as though provided in person or by other means.

2. An insurer shall not:

(a) Require an employee to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an employee through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1;

(c) Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an employee receives services through telehealth; or

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services.

3. A policy of insurance issued pursuant to chapters 616A to 617, inclusive, of NRS must not require an employee to obtain prior authorization for any service

provided through telehealth that is not required for the service when provided in person. Such a policy of insurance may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. The provisions of this section do not require an insurer to:

(a) Ensure that covered services are available to an employee through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) 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.

5. A policy of insurance subject to the provisions of chapters 616A to 617, inclusive, of NRS that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

6. As used in this section:

(a) “Distant site” has the meaning ascribed to it in NRS 629.515.

(b) “Originating site” has the meaning ascribed to it in NRS 629.515.

(c) “Provider of health care” has the meaning ascribed to it in NRS 439.820.

(d) “Telehealth” means the delivery of services from a provider of health care to a patient at a different location through a synchronous interaction using information and audio-visual communication technology, not including audio-only technology, facsimile or electronic mail.

### **Nev. Rev. Stat. § 695A.265**

*Coverage for services provided through telehealth required to same extent and in same amount as through provided in person or by other means; exception; prohibited acts*

1. A benefit contract must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.

2. A benefit contract must provide reimbursement for

services described in subsection 1 in the same amount as though provided in person or by other means:

(a) If the services:

(1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic; and

(2) Except for services described in paragraph (b), are not provided through audio-only interaction; or

(b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.

3. A society shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A benefit contract must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A benefit contract may require prior authorization for a service provided through telehealth if such prior authorization would

be required if the service were provided in person or by other means.

5. The provisions of this section do not require a society to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the society is not otherwise required by law to do so.

6. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.

7. As used in this section:

(a) "Distant site" has the meaning ascribed to it in NRS 629.515.

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(1)(2)(B).

(c) "Originating site" has the meaning ascribed to it in NRS 629.515.

(d) "Provider of health care" has the meaning ascribed to it in NRS 439.820.

(e) "Rural health clinic" has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

(f) "Telehealth" has the meaning ascribed to it in NRS 629.515.

#### **Nev. Rev. Stat. § 695B.1904**

*Required provision concerning coverage for services provided through telehealth to same extent and in same amount as though provided in person or by other means; exception; prohibited acts*

1. A contract for hospital, medical or dental services subject to the provisions of this chapter must include services provided to an insured through telehealth to the same extent as though provided in person or by other means.

2. A contract for hospital, medical or dental services must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means:

(a) If the services:

(1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic; and

(2) Except for services described in paragraph (b), are not provided through audio-only interaction; or

(b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.

3. A medical services corporation that issues contracts for hospital, medical or dental services shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A contract for hospital, medical or dental services must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A contract for hospital, medical or dental services may require prior authorization for a service provided through telehealth if such prior authorization would be

required if the service were provided in person or by other means.

5. The provisions of this section do not require a medical services corporation that issues contracts for hospital, medical or dental services to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the medical services corporation is not otherwise required by law to do so.

6. A contract for hospital, medical or dental services subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.

7. As used in this section:

(a) “Distant site” has the meaning ascribed to it in NRS 629.515.

(b) “Federally-qualified health center” has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) “Originating site” has the meaning ascribed to it in NRS 629.515.

(d) “Provider of health care” has the meaning ascribed to it in NRS 439.820.

(e) “Rural health clinic” has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

(f) “Telehealth” has the meaning ascribed to it in NRS 629.515.

### **Nev. Rev. Stat. § 695C.1708**

*Required provision concerning coverage for services provided through telehealth to same extent and in same amount as though provided in person or by other means; exception; prohibited acts*

1. A health care plan of a health maintenance organization must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means:

(a) If the services:

(1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a

federally-qualified health center or a rural health clinic; and

(2) Except for services described in paragraph (b), are not provided through audio-only interaction; or

(b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.

3. A health maintenance organization shall not:

(a) Require an enrollee to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) 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 to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an enrollee receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A health care plan of a health maintenance organization must 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. Such a health care plan may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. A health maintenance organization that provides medical services to recipients of Medicaid under the

State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services shall provide referrals to providers of dental services who provide services through teledentistry.

6. A health maintenance organization that provides dental services to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services shall:

(a) Maintain a list of providers of dental services included in the network of the health maintenance organization who offer services through teledentistry;

(b) At least quarterly, update the list and submit a copy of the updated list to the emergency department of each hospital located in this State; and

(c) Allow such providers of dental services to include on claim forms codes for teledentistry services provided through both real-time interactions and asynchronous transmissions of medical and dental information.

7. The provisions of this section do not require a health maintenance organization to:

(a) Ensure that covered services are available to an enrollee through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the health maintenance organization is not otherwise required by law to do so.

8. Evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

9. As used in this section:

(a) "Distant site" has the meaning ascribed to it in NRS 629.515.

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) "Originating site" has the meaning ascribed to it in NRS 629.515.

(d) “Provider of health care” has the meaning ascribed to it in NRS 439.820.

(e) “Rural health clinic” has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

(f) “Teledentistry” has the meaning ascribed to it in section 5 of this act.

(g) “Telehealth” has the meaning ascribed to it in NRS 629.515.

### **Nev. Rev. Stat. § 695D.216**

*Required provision concerning coverage for services provided through telehealth to same extent and in same amount as though provided in person or by other means; exception; prohibited acts*

1. A plan for dental care must include coverage for services provided to a member through telehealth to the same extent as though provided in person or by other means.
2. A plan for dental care must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means if the services:
  - (a) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic; and
  - (b) Are not provided through audio-only interaction.
3. An organization for dental care shall not:
  - (a) Require a member to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;
  - (b) Require a provider of health care to demonstrate that it is necessary to provide services to a member through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;
  - (c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:
    - (1) The distant site from which a provider of health care provides services through telehealth or the originating site at which a member receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A plan for dental care must not require a member to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A plan for dental care may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. The provisions of this section do not require an organization for dental care to:

- (a) Ensure that covered services are available to a member through telehealth at a particular originating site;
  - (b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or
  - (c) Enter into a contract with any provider of health care or cover any service if the organization for dental care is not otherwise required by law to do so.
6. A plan for dental care subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

7. As used in this section:

- (a) “Distant site” has the meaning ascribed to it in NRS 629.515.
- (b) “Federally-qualified health center” has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).
- (c) “Originating site” has the meaning ascribed to it in NRS 629.515.
- (d) “Provider of health care” has the meaning ascribed to it in NRS 439.820.
- (e) “Rural health clinic” has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).
- (f) “Telehealth” has the meaning ascribed to it in NRS 629.515.

## **Nev. Rev. Stat. § 695G.162**

*Required provision concerning coverage for services provided through telehealth to same extent and in same amount as though provided in person or by other means; exception; prohibited acts*

1. A health care plan issued by a managed care organization for group coverage must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.

2. A health care plan issued by a managed care organization for group coverage must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means:

(a) If the services:

(1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic; and

(2) Except for services described in paragraph (b), are not provided through audio-only interaction; or

(b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.

3. A managed care organization shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A health care plan of a managed care organization must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. Such a health care plan may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. A managed care organization that provides medical services to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services shall provide referrals to providers of dental services who provide services through teledentistry.

6. A managed care organization that provides dental services to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services shall:

(a) Maintain a list of providers of dental services included in the network of the managed care organization who offer services through teledentistry;

(b) At least quarterly, update the list and submit a copy of the updated list to the emergency department of each hospital located in this State; and

(c) Allow such providers of dental services to include on claim forms codes for teledentistry services provided through both real-time interactions and asynchronous transmissions of medical and dental information.

7. The provisions of this section do not require a managed care organization to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered





service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the managed care organization is not otherwise required by law to do so.

8. Evidence of coverage that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

9. As used in this section:

(a) “Distant site” has the meaning ascribed to it in NRS 629.515.

(b) “Federally-qualified health center” has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) “Originating site” has the meaning ascribed to it in NRS 629.515.

(d) “Provider of health care” has the meaning ascribed to it in NRS 439.820.

(e) “Rural health clinic” has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

(f) “Teledentistry” has the meaning ascribed to it in section 5 of this act.

(g) “Telehealth” has the meaning ascribed to it in NRS 629.515.

## **Nev. Rev. Stat. § 629.515**

*Valid license or certificate required; exception; restrictions; jurisdiction over and applicability of laws; conditions for establishment of relationship with patient using telehealth; regulations*

6. As used in this section:

(a) “Distant site” means the location of the site where a telehealth provider of health care is providing telehealth services to a patient located at an originating site.

(b) “Originating site” means the location of the site where a patient is receiving telehealth services from a provider of health care located at a distant site.

[...]

(e) “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 facsimile or electronic mail. The term includes, without limitation, communication between a provider of health care who is providing in-person services to a patient and a provider of health care at a different location and the delivery of services from a provider of health care to a patient at a different location through the use of:

(1) Synchronous interaction or an asynchronous system of storing and forwarding information; and

(2) Audio-only interaction, whether synchronous or asynchronous.

# NEW HAMPSHIRE

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# New Hampshire

**Authorities: N.H. Rev. Stat. §§ 415-J:2, 415-J:3, 420-J:8-e**

## **N.H. Rev. Stat. § 415-J:2**

### *Definitions*

In this chapter:

I. “Distant site” means the location of the health care provider delivering services through telemedicine at the time the services are provided.

I-a. “Health benefit policy” means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed in this state, including, but not limited to, those contracts executed by the state of New Hampshire on behalf of state employees under RSA 21-I, by an insurer.

II. “Insurer” means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, preferred provider organization, provider sponsored health care corporation, managed care entity, or any similar entity authorized to issue contracts under this title or to provide health benefit policies.

II-a. “Originating site” means 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, but not limited to, 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 the patient’s workplace.

II-b. “Remote patient monitoring” means the use of electronic technology to remotely monitor a patient’s health status through the collection and interpretation of clinical data while the patient remains at an originating site. Remote patient monitoring may or may not take place in real time. Remote patient monitoring shall include assessment, observation, education, and virtual visits provided by all covered providers including licensed home health care providers.

II-c. “Store and forward,” as it pertains to telemedicine, means the use of asynchronous electronic communications between a patient at an originating site and a health care service provider at a distant site for the purpose of diagnostic and therapeutic assistance in the care of patients. This includes the forwarding and or transfer of stored medical data from the originating site to the distant site through the use of any electronic device that records data in its own storage and forwards its data to the distant site via telecommunication for the purpose of diagnostic and therapeutic assistance.

III. “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 facsimile.

## **N.H. Rev. Stat. § 415-J:3**

### *Coverage for Telemedicine Services*

I. It is the intent of the general court to recognize the application of telemedicine for covered services provided within the scope of practice of a physician or other health care provider as a method of delivery of medical care by which an individual at an originating site shall receive medical services which are clinically appropriate for delivery through telemedicine from a health care provider at a distant site without in-person contact with the provider. For the purposes of this chapter, covered services include remote patient monitoring and store and forward.

II. An insurer offering a health plan in this state may not deny coverage 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.

III. An insurer offering a health plan in this state shall provide coverage and reimbursement for health care services provided through telemedicine on the same basis as the insurer provides coverage and reimbursement for health care services provided in person.



IV. An insurer shall provide reasonable compensation to an originating site operated by a health care provider or a licensed health care facility if the health care provider or licensed health care facility is authorized to bill the insurer directly for health care services. In the event of a dispute between a provider and an insurance carrier relative to the reasonable compensation under this section, the insurance commissioner shall have exclusive jurisdiction under RSA 420-J:8-e to determine if the compensation is commercially reasonable. The provider and the insurance carrier shall each make best efforts to resolve any dispute prior to applying to the insurance commissioner for resolution, which shall include presenting to the other party evidence supporting its contention that the compensation level it is proposing is commercially reasonable.

V. The combined amount of reimbursement that a health benefit plan allows for the compensation to the distant site and the originating site shall be the same as the total amount allowed for health care services provided in person.

VI. Nothing in this section shall be construed to prohibit an insurer from paying reasonable compensation to a provider at a distant site in addition to a fee paid to the health care provider.

VII. If an insurer excludes a health care service from its in-person reimbursable service, then comparable services shall not be reimbursable as a telemedicine service.

VIII. An insurer shall not impose on coverage for health care services provided through telemedicine any additional benefit plan limitations to include annual or lifetime dollar maximums on coverage, deductibles, copayments, coinsurance, benefit limitation or maximum benefits that are not equally imposed upon similar services provided in-person.

IX. Nothing in this section shall be construed to allow an insurer to reimburse more for a health care service provided through telemedicine than would have been reimbursed if the health care service was provided in person.

X. There shall be no restriction on eligible originating or distant sites for telehealth services. An originating site means the location of the member at the time the service is being furnished via a telecommunication system. A distant site means the location of the provider at the time the service is being furnished via a telecommunication system.

XI. An insurer shall provide reimbursement for all modes of telehealth, including video and audio, audio-only, or other electronic media provided by medical providers to treat all members for all medically necessary services.

XII. The following medical providers shall be allowed to perform health care services through the use of all modes of telehealth, including video and audio, audio-only, or other electronic media. Medical providers include, but are not limited to:

- (a) Physicians and physician assistants, under RSA 329 and RSA 328-D;
- (b) Advanced practice nurses, under RSA 326-B and registered nurses under RSA 326-B employed by home health care providers under RSA 151:2-b;
- (c) Midwives, under RSA 326-D;
- (d) Psychologists, under RSA 329-B;
- (e) Allied health professionals, under RSA 328-F;
- (f) Dentists, under RSA 317-A;
- (g) Mental health practitioners governed by RSA 330-A;
- (h) Community mental health providers employed by community mental health programs pursuant to RSA 135-C:7;
- (i) Alcohol and other drug use professionals, governed by RSA 330-C;
- (j) Dietitians, governed by RSA 326-H; and
- (k) Professionals certified by the national behavior analyst certification board or persons performing services under the supervision of a person certified by the national behavior analyst certification board as required by RSA 417-E:2.

XIII. Nothing in this section shall be construed to prohibit an insurer from providing coverage for only those services that are medically necessary and subject to the terms and conditions of the covered person's policy.

**N.H. Rev. Stat. § 420-J:8-e**

*Reasonable Value of Health Care Services*

In the event of a dispute between a health care provider and an insurance carrier relative to the reasonable value of a service under RSA 329:31-b [Prohibition on Balance Billing; Payment for Reasonable Value of Services] or RSA 415-J:3 [Coverage for Telemedicine Services], the commissioner shall have exclusive jurisdiction to determine if the fee is commercially reasonable. Either the provider or the insurance carrier may petition for a hearing under RSA 400-A:17. The petition shall include the appealing party's evidence and methodology for asserting that the fee is reasonable, and shall detail the efforts made by the parties to resolve the dispute prior to petitioning the commissioner for review. The department may require the parties to engage in mediation prior to rendering a decision.

## NEW JERSEY

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# New Jersey

**Authorities:** N.J. Stat. §§ 26:2S-29, 52:14-17.29w, 52:14-17.46.6h, 45:1-61

## N.J. Stat. § 26:2S-29

*Health Care Quality—Telemedicine and telehealth; coverage and payment for services*

a. A carrier that offers a health benefits plan in this State 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 in New Jersey, provided the services are otherwise covered under the plan when delivered through in-person contact and consultation in New Jersey. 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.

b. 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. In no case shall a carrier:

(1) impose any restrictions on the location or setting of the distant site used by a health care provider to provide services using telemedicine and telehealth or on the location or setting of the originating site where the patient is located when receiving services using telemedicine and telehealth, except to ensure that the services provided using telemedicine and telehealth meet the same standard of care as would be provided if the services were provided in person;

(2) restrict the ability of a provider to use any electronic or technological platform to provide services using telemedicine or telehealth, including, but not limited to, interactive, real-time, two-way audio, which may be used in combination with

asynchronous store-and-forward technology without video capabilities, including audio-only telephone conversations, to provide services using telemedicine or telehealth, provided that the platform used:

(a) allows the provider to meet the same standard of care as would be provided if the services were provided in person; and

(b) is compliant with the requirements of the federal health privacy rule set forth at 45 CFR Parts 160 and 164;

(3) deny coverage for or refuse to provide reimbursement for routine patient monitoring performed using telemedicine and telehealth, including remote monitoring of a patient's vital signs and routine check-ins with the patient to monitor the patient's status and condition, if coverage and reimbursement would be provided if those services are provided in person, and the provider is able to meet the same standard of care as would be provided if the services were provided in person; or

(4) limit coverage only to services delivered by select third-party telemedicine or telehealth organizations.

c. Nothing in this section shall be construed to:

(1) prohibit a carrier from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered person's health benefits plan; or

(2) allow a carrier to require a covered person to use telemedicine or telehealth in lieu of receiving an in-person service from an in-network provider.

d. The Commissioner of Banking and Insurance shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c. 410 (C.52:14B-1 et seq.), to implement the provisions of this section.

e. As used in this section:

"Asynchronous store-and-forward" means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

“Carrier” means the same as that term is defined by section 2 of P.L.1997, c. 192 (C.26:25-2).

“Covered person” means the same as that term is defined by section 2 of P.L.1997, c. 192 (C.26:2S-2).

“Distant site” means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

“Health benefits plan” means the same as that term is defined by section 2 of P.L.1997, c. 192 (C.26:2S-2).

“Originating site” means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

“Telehealth” means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

“Telemedicine” means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

“Telemedicine or telehealth organization” means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

#### **N.J. Stat. § 52:14-17.29w**

##### *Health Benefits--Officers and Employees— Telemedicine and telehealth; coverage and payment for services*

a. The State Health Benefits Commission shall ensure that every contract purchased thereby, which provides hospital and medical expense benefits, additionally provides 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 in New Jersey, provided the services are otherwise covered under the contract when delivered through in-person contact and consultation in New Jersey. 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.

b. A health benefits contract purchased by the State Health Benefits Commission 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. In no case shall a health benefits contract purchased by the State Health Benefits Commission:

(1) impose any restrictions on the location or setting of the distant site used by a health care provider to provide services using telemedicine and telehealth or on the location or setting of the originating site where the patient is located when receiving services using telemedicine and telehealth, except to ensure that the services provided using telemedicine and telehealth meet the same standard of care as would be provided if the services were provided in person;

(2) restrict the ability of a provider to use any electronic or technological platform to provide services using telemedicine or telehealth, including, but not limited to, interactive, real-time, two-way audio, which may be used in combination with asynchronous store-and-forward technology without video capabilities, including audio-only telephone conversations, to provide services using telemedicine or telehealth, provided that the platform used:

(a) allows the provider to meet the same standard of care as would be provided if the services were provided in person; and

(b) is compliant with the requirements of the federal health privacy rule set forth at 45 CFR Parts 160 and 164;

(3) deny coverage for or refuse to provide reimbursement for routine patient monitoring performed using telemedicine and telehealth, including remote monitoring of a patient’s vital signs and routine check-ins with the patient to monitor the patient’s status and condition, if coverage and reimbursement would be provided if those services are provided in person, and the provider is able to meet the same standard of care as would be provided if the services were provided in person; or

(4) limit coverage only to services delivered by select third-party telemedicine or telehealth organizations.

c. Nothing in this section shall be construed to:

(1) prohibit a health benefits contract from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered person’s health benefits plan; or



(2) allow the State Health Benefits Commission, or a contract purchased thereby, to require a covered person to use telemedicine or telehealth in lieu of receiving an in-person service from an in-network provider.

d. The State Health Benefits Commission shall adopt rules and regulations, pursuant to the “Administrative Procedure Act,” P.L.1968, c. 410 (C.52:14B-1 et seq.), to implement the provisions of this section.

e. As used in this section:

“Asynchronous store-and-forward” means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

“Distant site” means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

“Originating site” means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

“Telehealth” means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

“Telemedicine” means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

“Telemedicine or telehealth organization” means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

#### **N.J. Stat. § 52:14-17.46.6h**

*Health Benefits--Officers and Employees—  
Telemedicine and telehealth; coverage and payment  
for services*

a. The School Employees’ Health Benefits Commission shall ensure that every contract purchased thereby, which provides hospital and medical expense benefits, additionally provides 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 in New Jersey, provided the services are otherwise covered under the contract when delivered through in-person contact and consultation in New Jersey. 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.

b. A health benefits contract purchased by the School Employees’ Health Benefits Commission 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. In no case shall a health benefits contract purchased by the School Employees’ Health Benefits Commission:

(1) impose any restrictions on the location or setting of the distant site used by a health care provider to provide services using telemedicine and telehealth or on the location or setting of the originating site where the patient is located when receiving services using telemedicine and telehealth, except to ensure that the services provided using telemedicine and telehealth meet the same standard of care as would be provided if the services were provided in person;

(2) restrict the ability of a provider to use any electronic or technological platform to provide services using telemedicine or telehealth, including, but not limited to, interactive, real-time, two-way audio, which may be used in combination with asynchronous store-and-forward technology without video capabilities, including audio-only telephone conversations, to provide services using telemedicine or telehealth, provided that the platform used:

(a) allows the provider to meet the same standard of care as would be provided if the services were provided in person; and

(b) is compliant with the requirements of the federal health privacy rule set forth at 45 CFR Parts 160 and 164;

(3) deny coverage for or refuse to provide reimbursement for routine patient monitoring performed using telemedicine and telehealth, including remote monitoring of a patient’s vital signs and routine check-ins with the patient to monitor the patient’s status and condition, if coverage and reimbursement would be provided if those services are provided in person, and the provider is able to meet the same standard of care as would be provided if the services were provided in person; or

(4) limit coverage only to services delivered by select third-party telemedicine or telehealth organizations.



c. Nothing in this section shall be construed to:

(1) prohibit a health benefits contract from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered person's health benefits plan; or

(2) allow the School Employees' Health Benefits Commission, or a contract purchased thereby, to require a covered person to use telemedicine or telehealth in lieu of receiving an in-person service from an in-network provider.

d. The School Employees' Health Benefits Commission shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c. 410 (C.52:14B-1 et seq.), to implement the provisions of this section.

e. As used in this section:

"Asynchronous store-and-forward" means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

"Distant site" means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

"Originating site" means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

"Telehealth" means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

"Telemedicine" means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

"Telemedicine or telehealth organization" means the same as that term is defined by section 1 of P.L.2017, c. 117 (C.45:1-61).

## **N.J. Stat. § 45:1-61**

### *Telemedicine and Telehealth—Definitions*

"Asynchronous store-and-forward" means the acquisition and transmission of images, diagnostics, data, and medical information either to, or from, an originating site or to, or from, the health care provider at a distant site, which allows for the patient to be evaluated without being physically present.

[...]

"Distant site" means a site at which a health care provider, acting within the scope of a valid license or certification issued pursuant to Title 45 of the Revised Statutes, is located while providing health care services by means of telemedicine or telehealth.

[...]

"Originating site" means a site at which a patient is located at the time that health care services are provided to the patient by means of telemedicine or telehealth.

[...]

"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 in accordance with the provisions of P.L.2017, c. 117 (C.45:1-61 et al.).

"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, and in accordance with the provisions of P.L.2017, c. 117 (C.45:1-61 et al.). "Telemedicine" does not include the use, in isolation, electronic mail, instant messaging, phone text, or facsimile transmission.

"Telemedicine or telehealth organization" means a corporation, sole proprietorship, partnership, or limited liability company that is organized for the primary purpose of administering services in the furtherance of telemedicine or telehealth. [...]

## NEW MEXICO

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# New Mexico

**Authorities: N.M. Stat. § 13-7-14; N.M. Stat. § 59A-46-50.3; N.M. Stat. § 59A-22-49.3; N.M. Stat. § 59A-23-7.12; N.M. Stat. § 59A-47-45.3**

## **N.M. Stat. § 13-7-14**

*Health Care Purchasing—Coverage for telemedicine services*

A. Group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act shall provide coverage for services provided via telemedicine to the same extent that the group health plan covers the same services when those services are provided via in-person consultation or contact. A group health plan shall not impose any unique condition for coverage of services provided via telemedicine.

B. A group health plan shall not impose an originating-site restriction with respect to telemedicine services or distinguish between telemedicine services provided to patients in rural locations and those provided to patients in urban locations; provided that the provisions of this section shall not be construed to require coverage of an otherwise noncovered benefit.

C. A determination by a group health plan that health care services delivered through the use of telemedicine are not covered under the plan shall be subject to review and appeal pursuant to the Patient Protection Act.

D. The provisions of this section shall not apply in the event that federal law requires the state to make payments on behalf of enrollees to cover the costs of implementing this section.

E. Nothing in this section shall require a health care provider to be physically present with a patient at the originating site unless the consulting telemedicine provider deems it necessary.

F. A group health plan shall not limit coverage of services delivered via telemedicine only to those health care providers who are members of the group health plan provider network where no in-network provider is available and accessible, as availability and accessibility are defined in network adequacy standards issued by the superintendent of insurance.

G. A group health plan may charge a deductible, copayment or coinsurance for a health care service delivered via telemedicine if it does not exceed the deductible, copayment or coinsurance applicable to a service delivered via in-person consultation or contact.

H. A group health plan shall not impose any annual or lifetime dollar maximum on coverage for services delivered via telemedicine, other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the group health plan, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance or deductible amounts, or any plan year, calendar year, lifetime or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the group health plan.

I. A group health plan shall reimburse for health care services delivered via telemedicine on the same basis and at least the same rate that the group health plan reimburses for comparable services delivered via in-person consultation or contact.

J. Telemedicine used to provide clinical services shall be encrypted and shall conform to state and federal privacy laws.

K. The provisions of this section shall not apply to group health coverage intended to supplement major medical group-type coverage, such as Medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy.

L. As used in this section:

(1) “consulting telemedicine provider” means a health care provider that delivers telemedicine services from a location remote from an originating site;

(2) “health care provider” means a duly licensed hospital or other licensed facility, physician or other health care professional authorized to furnish health care services within the scope of the professional’s license;

(3) “in real time” means occurring simultaneously, instantaneously or within seconds of an event so that there is little or no noticeable delay between two or more events;

(4) “originating site” means a place at which a patient is physically located and receiving health care services via telemedicine;

(5) “store-and-forward technology” means electronic information, imaging and communication, including interactive audio, video and data communications, that is transferred or recorded or otherwise stored for asynchronous use; and

(6) “telemedicine” means the use of telecommunications and information technology to provide clinical health care at a site distinct from the patient. “Telemedicine” allows health care professionals to evaluate, diagnose and treat patients in remote locations using telecommunications and information technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver health care services to a site where the patient is located, along with the use of electronic media and health information. “Telemedicine” allows patients in remote locations to access medical expertise without travel.

### **N.M. Stat. § 59A-46-50.3**

#### *Health Maintenance Organizations—Coverage for telemedicine services*

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state shall provide coverage for services provided via telemedicine to the same extent that the contract covers the same services when those services are provided via in-person consultation or contact. A carrier shall not impose any unique condition for coverage of services provided via telemedicine.

B. A carrier shall not impose an originating-site restriction with respect to telemedicine services or distinguish between telemedicine services provided to patients in rural locations and those provided to patients in urban locations; provided that the provisions of this section shall not be construed to require coverage of an otherwise noncovered benefit.

C. A determination by a health maintenance organization that health care services delivered through the use of telemedicine are not covered under the plan shall be subject to review and appeal pursuant to the Patient Protection Act.

D. The provisions of this section shall not apply in the event that federal law requires the state to make payments on behalf of enrollees to cover the costs of implementing this section.

E. Nothing in this section shall require a health care provider to be physically present with a patient at the originating site unless the consulting telemedicine provider deems it necessary.

F. A carrier shall not limit coverage of services delivered via telemedicine only to those health care providers who are members of the health maintenance organization contract provider network where no in-network provider is available and accessible, as availability and accessibility are defined in network adequacy standards issued by the superintendent.

G. A carrier may charge a deductible, copayment or coinsurance for a health care service delivered via telemedicine if it does not exceed the deductible, copayment or coinsurance applicable to a service delivered via in-person consultation or contact.

H. A carrier shall not impose any annual or lifetime dollar maximum on coverage for services delivered via telemedicine, other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the contract, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance or deductible amounts, or any contract year, calendar year, lifetime or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the contract.

I. A carrier shall reimburse for health care services delivered via telemedicine on the same basis and at least the same rate that the carrier reimburses for comparable services delivered via in-person consultation or contact.

J. Telemedicine used to provide clinical services shall be encrypted and shall conform to state and federal privacy laws.

K. The provisions of this section shall not apply to an individual or group health maintenance organization

contract intended to supplement major medical group-type coverage, such as Medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy.

L. As used in this section:

(1) “consulting telemedicine provider” means a health care provider that delivers telemedicine services from a location remote from an originating site;

(2) “in real time” means occurring simultaneously, instantaneously or within seconds of an event so that there is little or no noticeable delay between two or more events;

(3) “originating site” means a place at which a patient is physically located and receiving health care services via telemedicine;

(4) “store-and-forward technology” means electronic information, imaging and communication, including interactive audio, video and data communication, that is transferred or recorded or otherwise stored for asynchronous use; and

(5) “telemedicine” means the use of telecommunications and information technology to provide clinical health care from a distance. “Telemedicine” allows health care professionals to evaluate, diagnose and treat patients in remote locations using telecommunications and information technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver health care services to a site where the patient is located, along with the use of electronic media and health information. “Telemedicine” allows patients in remote locations to access medical expertise without travel.

### **N.M. Stat. § 59A-22-49.3**

#### *Health Insurance Contracts—Coverage for telemedicine services*

A. An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state shall provide coverage for services provided via telemedicine to the same extent that the health insurance plan, policy or contract covers the same services when those services are provided via in-

person consultation or contact. An insurer shall not impose any unique condition for coverage of services provided via telemedicine.

B. An insurer shall not impose an originating-site restriction with respect to telemedicine services or distinguish between telemedicine services provided to patients in rural locations and those provided to patients in urban locations; provided that the provisions of this section shall not be construed to require coverage of an otherwise noncovered benefit.

C. A determination by an insurer that health care services delivered through the use of telemedicine are not covered under the plan shall be subject to review and appeal pursuant to the Patient Protection Act.

D. The provisions of this section shall not apply in the event that federal law requires the state to make payments on behalf of enrollees to cover the costs of implementing this section.

E. Nothing in this section shall require a health care provider to be physically present with a patient at the originating site unless the consulting telemedicine provider deems it necessary.

F. An insurer shall not limit coverage of services delivered via telemedicine only to those health care providers who are members of the health insurance plan, policy or contract provider network where no in-network provider is available and accessible, as availability and accessibility are defined in network adequacy standards issued by the superintendent.

G. An insurer may charge a deductible, copayment, or coinsurance for a health care service delivered via telemedicine if it does not exceed the deductible, copayment or coinsurance applicable to a service delivered via in-person consultation or contact.

H. An insurer shall not impose any annual or lifetime dollar maximum on coverage for services delivered via telemedicine, other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the health insurance plan, policy or contract, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance or deductible amounts, or any plan, policy or contract year, calendar year, lifetime or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the health insurance plan, policy or contract.

I. An insurer shall reimburse for health care services delivered via telemedicine on the same basis and at least the same rate that the insurer reimburses for comparable services delivered via in-person consultation or contact.

J. Telemedicine used to provide clinical services shall be encrypted and shall conform to state and federal privacy laws.

K. The provisions of this section shall not apply to an individual policy, plan or contract intended to supplement major medical group-type coverage, such as Medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy.

L. As used in this section:

(1) “consulting telemedicine provider” means a health care provider that delivers telemedicine services from a location remote from an originating site;

(2) “health care provider” means a duly licensed hospital or other licensed facility, physician or other health care professional authorized to furnish health care services within the scope of the professional’s license;

(3) “in real time” means occurring simultaneously, instantaneously or within seconds of an event so that there is little or no noticeable delay between two or more events;

(4) “originating site” means a place at which a patient is physically located and receiving health care services via telemedicine;

(5) “store-and-forward technology” means electronic information, imaging and communication, including interactive audio, video and data communication, that is transferred or recorded or otherwise stored for asynchronous use; and

(6) “telemedicine” means the use of telecommunications and information technology to provide clinical health care from a distance. “Telemedicine” allows health care professionals to evaluate, diagnose and treat patients in remote locations using telecommunications and information technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver

health care services to a site where the patient is located, along with the use of electronic media and health information. “Telemedicine” allows patients in remote locations to access medical expertise without travel.

#### **N.M. Stat. § 59A-23-7.12**

##### *Group and Blanket Health Insurance Contracts—Coverage for telemedicine services*

A. A blanket or group health insurance policy or contract that is delivered, issued for delivery or renewed in this state shall provide coverage for services provided via telemedicine to the same extent that the health insurance plan, policy or contract covers the same services when those services are provided via in-person consultation or contact. An insurer shall not impose any unique condition for coverage of services provided via telemedicine.

B. An insurer shall not impose an originating-site restriction with respect to telemedicine services or distinguish between telemedicine services provided to patients in rural locations and those provided to patients in urban locations; provided that the provisions of this section shall not be construed to require coverage of an otherwise noncovered benefit.

C. A determination by an insurer that health care services delivered through the use of telemedicine are not covered under the plan shall be subject to review and appeal pursuant to the Patient Protection Act.

D. The provisions of this section shall not apply in the event that federal law requires the state to make payments on behalf of enrollees to cover the costs of implementing this section.

E. Nothing in this section shall require a health care provider to be physically present with a patient at the originating site unless the consulting telemedicine provider deems it necessary.

F. An insurer shall not limit coverage of services delivered via telemedicine only to those health care providers who are members of the health insurance plan, policy or contract provider network where no in-network provider is available and accessible, as availability and accessibility are defined in network adequacy standards issued by the superintendent.

G. An insurer may charge a deductible, copayment or coinsurance for a health care service delivered via telemedicine if it does not exceed the deductible,



copayment or coinsurance applicable to a service delivered via in-person consultation or contact.

H. An insurer shall not impose any annual or lifetime dollar maximum on coverage for services delivered via telemedicine, other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the health insurance plan, policy or contract, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance or deductible amounts, or any plan, policy or contract year, calendar year, lifetime or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the health insurance plan, policy or contract.

I. An insurer shall reimburse for health care services delivered via telemedicine on the same basis and at least the same rate that the insurer reimburses for comparable services delivered via in-person consultation or contact.

J. Telemedicine used to provide clinical services shall be encrypted and shall conform to state and federal privacy laws.

K. The provisions of this section shall not apply to a group or blanket policy, plan or contract intended to supplement major medical group-type coverage, such as medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy.

L. As used in this section:

(1) “consulting telemedicine provider” means a health care provider that delivers telemedicine services from a location remote from an originating site;

(2) “health care provider” means a duly licensed hospital or other licensed facility, physician or other health care professional authorized to furnish health care services within the scope of the professional’s license;

(3) “in real time” means occurring simultaneously, instantaneously or within seconds of an event so that there is little or no noticeable delay between two or more events;

(4) “originating site” means a place at which a patient is physically located and receiving health care services via telemedicine;

(5) “store-and-forward technology” means electronic information, imaging and communication, including interactive audio, video and data communication, that is transferred or recorded or otherwise stored for asynchronous use; and

(6) “telemedicine” means the use of telecommunications and information technology to provide clinical health care from a distance. “Telemedicine” allows health care professionals to evaluate, diagnose and treat patients in remote locations using telecommunications and information technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver health care services to a site where the patient is located, along with the use of electronic media and health information. “Telemedicine” allows patients in remote locations to access medical expertise without travel.

### **N.M. Stat. § 59A-47-45.3**

#### *Nonprofit Health Care Plans—Coverage for telemedicine services*

A. An individual or group health insurance policy, health care plan or certificate of health insurance delivered or issued for delivery in this state shall provide coverage for services provided via telemedicine to the same extent the health care plan covers the same services when those services are provided via in-person consultation or contact. A health care plan shall not impose any unique condition for coverage of services provided via telemedicine.

B. A health care plan shall not impose an originating-site restriction with respect to telemedicine services or distinguish between telemedicine services provided to patients in rural locations and those provided to patients in urban locations; provided that the provisions of this section shall not be construed to require coverage of an otherwise noncovered benefit.

C. A determination by a nonprofit health plan that health care services delivered through the use of telemedicine are not covered under the plan shall be subject to review and appeal pursuant to the Patient Protection Act.

D. The provisions of this section shall not apply in the event that federal law requires the state to make



payments on behalf of enrollees to cover the costs of implementing this section.

E. Nothing in this section shall require a health care provider to be physically present with a patient at the originating site unless the consulting telemedicine provider deems it necessary.

F. A health care plan shall not limit coverage of services delivered via telemedicine only to those health care providers who are members of the health care plan provider network where no in-network provider is available and accessible, as availability and accessibility are defined in network adequacy standards issued by the superintendent.

G. A health care plan may charge a deductible, copayment or coinsurance for a health care service delivered via telemedicine if it does not exceed the deductible, copayment or coinsurance applicable to a service delivered via in-person consultation or contact.

H. A health care plan shall not impose any annual or lifetime dollar maximum on coverage for services delivered via telemedicine, other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the health care plan, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance or deductible amounts, or any plan year, calendar year, lifetime or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the health care plan.

I. A health care plan shall reimburse for health care services delivered via telemedicine on the same basis and at least the same rate that the carrier reimburses for comparable services delivered via in-person consultation or contact.

J. Telemedicine used to provide clinical services shall be encrypted and shall conform to state and federal privacy laws.

K. The provisions of this section shall not apply to an individual or group health care plan intended to supplement major medical group-type coverage, such

as Medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or any other limited-benefit health insurance policy.

L. As used in this section:

(1) “consulting telemedicine provider” means a health care provider that delivers telemedicine services from a location remote from an originating site;

(2) “health care provider” means a duly licensed hospital or other licensed facility, physician or other health care professional authorized to furnish health care services within the scope of the professional’s license;

(3) “in real time” means occurring simultaneously, instantaneously or within seconds of an event so that there is little or no noticeable delay between two or more events;

(4) “originating site” means a place at which a patient is physically located and receiving health care services via telemedicine;

(5) “store-and-forward technology” means electronic information, imaging and communication, including interactive audio, video and data communication, that is transferred or recorded or otherwise stored for asynchronous use; and

(6) “telemedicine” means the use of telecommunications and information technology to provide clinical health care from a distance. “Telemedicine” allows health care professionals to evaluate, diagnose and treat patients in remote locations using telecommunications and information technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver health care services to a site where the patient is located, along with the use of electronic media and health information. “Telemedicine” allows patients in remote locations to access medical expertise without travel.

## NEW YORK

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# New York

**Authorities: N.Y. Ins. Law § 3217-h; N.Y. Ins. Law § 4306-g; N.Y. Pub. Health Law § 4406-g**

## **N.Y. Ins. Law § 3217-h**

*Insurance Contracts—Life, Accident and Health Annuities—Telehealth delivery of services*

(a)[Eff. until April 1, 2024, pursuant to L.2022, c. 57, pt. V, § 7. See, also, subsec. (a) below.] (1) An insurer shall not exclude from coverage a service that is otherwise covered under a policy that provides comprehensive coverage for hospital, medical or surgical care because the service is delivered via telehealth, as that term is defined in subsection (b) of this section; provided, however, that an insurer may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the policy. An insurer may subject the coverage of a service delivered via telehealth to copayments, coinsurance or deductibles provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth. An insurer may subject the coverage of a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

(2) An insurer that provides comprehensive coverage for hospital, medical or surgical care shall reimburse covered services delivered by means of telehealth on the same basis, at the same rate, and to the same extent that such services are reimbursed when delivered in person; provided that reimbursement of covered services delivered via telehealth shall not require reimbursement of costs not actually incurred in the provision of the telehealth services, including charges related to the use of a clinic or other facility when neither the originating site nor distant site occur within the clinic or other facility.

(3) An insurer that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically appropriate.

(a) [Eff. April 1, 2024, pursuant to L.2022, c. 57, pt. V, § 7. See, also, subsec. (a) above.] An insurer shall not exclude from coverage a service that is otherwise covered under a policy that provides comprehensive coverage for hospital, medical or surgical care because the service is delivered via telehealth, as that term is defined in subsection (b) of this section; provided, however, that an insurer may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the policy. An insurer may subject the coverage of a service delivered via telehealth to co-payments, coinsurance or deductibles provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth. An insurer may subject the coverage of a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

(b) For purposes of this section, “telehealth” means the use of electronic information and communication technologies by a health care provider to deliver health care 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.

## **N.Y. Pub. Health Law § 4406-g**

*Health Maintenance Organizations—Telehealth delivery of services*

1. A health maintenance organization shall not exclude from coverage a service that is otherwise covered under an enrollee contract of a health maintenance organization because the service is delivered via telehealth, as that term is defined in subdivision two of this section; provided, however, that a health maintenance organization may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the enrollee contract. A health maintenance organization may subject the coverage of a service delivered via telehealth to copayments, coinsurance or deductibles provided that they are at least as favorable to the enrollee as those

established for the same service when not delivered via telehealth. A health maintenance organization may subject the coverage of a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

2. For purposes of this section, “telehealth” means the use of electronic information and communication technologies by a health care provider to deliver health care services to an enrollee while such enrollee is located at a site that is different from the site where the health care provider is located.

3. [Expires and deemed repealed April 1, 2024, pursuant to L.2022, c. 57, pt. V, § 7.] A health maintenance organization that provides comprehensive coverage for hospital, medical or surgical care shall reimburse covered services delivered via telehealth on the same basis, at the same rate, and to the extent that such services are reimbursed when delivered in person; provided that reimbursement of covered services delivered by means of telehealth shall not require reimbursement of costs not actually incurred in the provision of the telehealth services, including charges related to the use of a clinic or other facility when neither the originating site nor the distant site occur within the clinic or other facility. The commissioner, in consultation with the superintendent, may promulgate regulations to implement the provisions of this section.

4. [Expires and deemed repealed April 1, 2024, pursuant to L.2022, c. 57, pt. V, § 7.] A health maintenance organization that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically appropriate.

#### **N.Y. Ins. Law § 4306-g.**

*Non-Profit Medical and Dental Indemnity, or Health and Hospital Service Corporations—Telehealth delivery of services*

(a) [Eff. until April 1, 2024, pursuant to L.2022, c. 55, pt. V, § 7. See, also, subsec. (a) below.] (1) A corporation shall not exclude from coverage a service that is otherwise covered under a contract that provides comprehensive coverage for hospital, medical

or surgical care because the service is delivered via telehealth, as that term is defined in subsection (b) of this section; provided, however, that a corporation may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the contract. A corporation may subject the coverage of a service delivered via telehealth to copayments, coinsurance or deductibles provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth. A corporation may subject the coverage of a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

(2) A corporation that provides comprehensive coverage for hospital, medical or surgical care shall reimburse covered services delivered by means of telehealth on the same basis, at the same rate, and to the same extent that such services are reimbursed when delivered in person; provided that reimbursement of covered services delivered via telehealth shall not require reimbursement of costs not actually incurred in the provision of the telehealth services, including charges related to the use of a clinic or other facility when neither the originating site nor the distant site occur within the clinic or other facility. The superintendent may promulgate regulations to implement the provisions of this section.

(3) A corporation that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically appropriate.

(a) [Eff. April 1, 2024, pursuant to L.2022, c. 55, pt. V, § 7. See, also, subsec. (a) above.] A corporation shall not exclude from coverage a service that is otherwise covered under a contract that provides comprehensive coverage for hospital, medical or surgical care because the service is delivered via telehealth, as that term is defined in subsection (b) of this section; provided, however, that a corporation may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the contract. A corporation may subject the coverage of a service delivered via telehealth to co-payments, coinsurance or deductibles provided that they are at least as

favorable to the insured as those established for the same service when not delivered via telehealth. A corporation may subject the coverage of a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

(b) For purposes of this section, “telehealth” means the use of electronic information and communication technologies by a health care provider to deliver health care 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.



## NORTH CAROLINA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A



# North Carolina

There are currently no commercial payer telehealth statutes in this state.



## NORTH DAKOTA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

\* telehome monitoring

Yes     No     Limited     N/A

# North Dakota

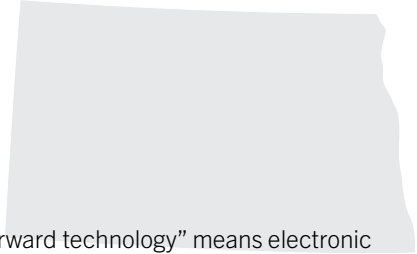
**Authority: N.D. Cent. Code § 26.1-36-09.15**

## **N.D. Cent. Code § 26.1-36-09.15**

### *Coverage of telehealth services*

1. As used in this section:

- a. “Distant site” means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.
- b. “E-visit” means a face-to-face digital communication initiated by a patient to a provider through the provider’s online patient portal.
- c. “Health care facility” means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.
- d. “Health care provider” includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.
- e. “Nonpublic facing product” means a remote communication product that, as a default, allows only the intended parties to participate in the communication.
- f. “Originating site” means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.
- g. “Policy” means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.
- h. “Secure connection” means a connection made using a nonpublic facing remote communication product that employs end-to-end encryption, and which allows only an individual and the person with whom the individual is communicating to see what is transmitted.



i. “Store-and-forward technology” means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a distant site at a later date by a health care provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video, and data communication.

j. “Telehealth”:

(1) 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.

(2) 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.

(3) Does not include the use of electronic mail, facsimile transmissions, or audio-only telephone, unless for the purpose of e-visits or a virtual check-in.

k. “Virtual check-in” means a brief communication via telephone or other telecommunications device to decide whether an office visit or other service is needed.

2. An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage unless that policy provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.

3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may be established through negotiations conducted by the insurer with the health services providers in the same manner as the insurer





establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.

4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions.

5. This section does not require:

- a. A policy to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy;
- b. A policy to provide coverage for health services delivered by means of telehealth if the policy would not provide coverage for the health services if delivered by in-person means;
- c. A policy to reimburse a health care provider or health care facility for expenses for health services delivered by means of telehealth if the policy would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or
- d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary.

## OHIO

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A

# Ohio

**Authority: Ohio Rev. Code § 3902.30; Ohio Rev. Code § 4743.09**

## Ohio Rev. Code § 3902.30

*Telehealth services coverage; basis and extent*

(A) As used in this section:

(1) “Cost sharing” means the cost to a covered individual under a health benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the plan.

(2) “Health benefit plan,” “health care services,” and “health plan issuer” have the same meanings as in section 3922.01 of the Revised Code.

(3) “Health care professional” has the same meaning as in section 4743.09 of the Revised Code.

(4) “In-person health care services” means health care services delivered by a health care professional through the use of any communication method where the professional and patient are simultaneously present in the same geographic location.

(5) “Telehealth services” has the same meaning as in section 4743.09 of the Revised Code.

(B)(1) A health benefit plan shall provide coverage for telehealth services on the same basis and to the same extent that the plan provides coverage for the provision of in-person health care services.

(2) A health benefit plan shall not exclude coverage for a service solely because it is provided as a telehealth service.

(3) A health plan issuer shall reimburse a health care professional for a telehealth service that is covered under a patient’s health benefit plan. Division (B)(3) of this section shall not be construed to require a specific reimbursement amount.

(C) A health benefit plan shall not impose any annual or lifetime benefit maximum in relation to telehealth services other than such a benefit maximum imposed on all benefits offered under the plan.

(D)(1) A health benefit plan shall not impose a cost-sharing requirement for telehealth services that exceeds the cost-sharing requirement for comparable in-person health care services.

(2)(a) A health benefit plan shall not impose a cost-sharing

requirement for a communication when all of the following apply:

(i) The communication was initiated by the health care professional.

(ii) The patient consented to receive a telehealth service from that provider on any prior occasion.

(iii) The communication is conducted for the purposes of preventive health care services only.

(b) If a communication described in division (D)(2)(a) of this section is coded based on time, then only the time the health care professional spends engaged in the communication is billable.

(E) This section shall not be construed as doing any of the following:

(1) Requiring a health plan issuer to reimburse a health care professional for any costs or fees associated with the provision of telehealth services that would be in addition to or greater than the standard reimbursement for comparable in-person health care services;

(2) Requiring a health plan issuer to reimburse a telehealth provider for telehealth services at the same rate as in-person services;

(3) Requiring a health plan issuer to provide coverage for asynchronous communication that differs from the coverage described in the applicable health benefit plan.

(F) The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to carry out the requirements of this section. Any such rules adopted by the superintendent are not subject to the requirements of division (F) of section 121.95 of the Revised Code.

## Ohio Rev. Code § 4243.09

(6) “Telehealth services” means health care services provided through the use of information and communication technology by a health care professional, within the professional’s scope of practice, who is located at a site other than the site where either of the following is located:

(a) The patient receiving the services;

(b) Another health care professional with whom the provider of the services is consulting regarding the patient.

## OKLAHOMA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A



# Oklahoma



**Authorities: 36 Okla. St. §§ 6802, 6803**

## 36 Okla. St. § 6802

### *Telemedicine defined*

As used in the Oklahoma Telemedicine Act:

1. “Distant site” means a site at which a health care professional licensed to practice in this state is located while providing health care services by means of telemedicine;

2. a. “Health benefits plan” means any plan or arrangement that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident or illness, and

(2) is offered by any insurance company, group hospital service corporation or health maintenance organization that delivers or issues for delivery an individual, group, blanket or franchise insurance policy or insurance agreement, a group hospital service contract or an evidence of coverage, or, to the extent permitted by the Employee Retirement Income Security Act of 1974, 29 U.S.C., Section 1001 et seq., by a multiple employer welfare arrangement as defined in Section 3 of the Employee Retirement Income Security Act of 1974, or any other analogous benefit arrangement, whether the payment is fixed or by indemnity,

b. Health benefits plan shall not include:

(1) a plan that provides coverage:

(a) only for a specified disease or diseases or under an individual limited benefit policy,

(b) only for accidental death or dismemberment,

(c) only for dental or vision care,

(d) for a hospital confinement indemnity policy,

(e) for disability income insurance or a combination of accident-only and disability income insurance, or

(f) as a supplement to liability insurance,

(2) a Medicare supplemental policy as defined by Section 1882(g)(1) of the Social Security Act (42 U.S.C., Section 1395ss),

(3) workers’ compensation insurance coverage,

(4) medical payment insurance issued as part of a motor vehicle insurance policy,

(5) a long-term care policy including a nursing home fixed indemnity policy, unless a determination is made that the policy provides benefit coverage so comprehensive that the policy meets the definition of a health benefits plan,

(6) short-term health insurance issued on a nonrenewable basis with a duration of six (6) months or less, or

(7) a plan offered by the Employees Group Insurance Division of the Office of Management and Enterprise Services;

3. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law;

4. “Insurer” means any entity providing an accident and health insurance policy in this state including, but not limited to, a licensed insurance company, a not-for-profit hospital services and medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement or any other entity subject to regulation by the Insurance Commissioner;

5. “Originating site” means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine, which may include, but shall not be restricted to, a patient’s home, workplace or school;

6. “Remote patient monitoring services” means the delivery of home health services using telecommunications technology to enhance the delivery of home health care including monitoring of

clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose and other condition-specific data, medication adherence monitoring and interactive video conferencing with or without digital image upload;

7. “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the health care professional at the distant site, but does not require the patient being present nor must it be in real time; and

8. “Telemedicine” or “telehealth” means technology-enabled health and care management and delivery systems that extend capacity and access, which includes:

a. synchronous mechanisms, which may include live audiovisual interaction between a patient and a health care professional or real-time provider-to-provider consultation through live interactive audiovisual means,

b. asynchronous mechanisms, which include store and forward transfers, online exchange of health information between a patient and a health care professional and online exchange of health information between health care professionals, but shall not include the use of automated text messages or automated mobile applications that serve as the sole interaction between a patient and a health care professional,

c. remote patient monitoring, and

d. other electronic means that support clinical health care, professional consultation, patient and professional health-related education, public health and health administration.

### **36 Okla. St. § 6803**

#### *Coverage of services – Requirements for insurers*

A. Services that a health care professional determines to be appropriately provided by means of telemedicine, health care service plans, disability insurer programs, workers’ compensation programs or state Medicaid managed care program contracts issued, amended or renewed on or after January 1, 1998, shall not require person-to-person contact between a health care professional and a patient.

B. Subsection A of this section shall apply to health care service plan contracts with the state Medicaid managed care program only to the extent that both of the following apply:

1. Telemedicine services are covered by, and reimbursed under, the fee-for-service provisions of the state Medicaid managed care program; and

2. State Medicaid managed care program contracts with health care service plans are amended to add coverage of telemedicine services and make any appropriate capitation rate adjustments.

C. Any health benefit plan that is offered, issued or renewed in this state by an insurer on or after the effective date of this act shall provide coverage of health care services provided through telemedicine, as provided in this section.

D. An insurer shall not exclude a service for coverage solely because the service is provided through telemedicine and is not provided through in-person consultation or contact between a health care professional and a patient when such services are appropriately provided through telemedicine. An insurer may limit coverage of services provided by telehealth consistent with coding and clinical standards recognized by the American Medical Association or the Centers for Medicare and Medicaid Services as covered if delivered by telehealth or telemedicine, except as agreed to by the insurer and provider.

E. An insurer shall reimburse the treating health care professional or the consulting health care professional for the diagnosis, consultation or treatment of the patient delivered through telemedicine services on the same basis and at least at the rate of reimbursement that the insurer is responsible for coverage for the provision of the same, or substantially similar, services through in-person consultation or contact.

F. An insurer shall not apply any deductible to telemedicine services that accumulates separately from the deductible that applies in the aggregate to all items and services covered under the health benefit plan.

G. Any copayment or coinsurance applied to telemedicine benefits by an insurer shall not exceed the copayment or coinsurance applied to such benefits when provided through in-person consultation or contact.

H. An insurer shall not impose any annual or lifetime durational limits or annual or lifetime dollar maximums for benefits or services provided through telemedicine that are not equally imposed upon all terms and services covered under the health benefit plan.

I. An insurer shall not impose any type of utilization review on benefits provided through telemedicine unless such type of utilization review is imposed when such benefits are provided through in-person consultation or contact. Any type of utilization review that is imposed on benefits provided through telemedicine shall not occur with greater frequency or more stringent application than such form of utilization review is imposed on such benefits provided through in-person consultation or contact.

J. An insurer shall not restrict coverage of telemedicine benefits or services to benefits or services provided by a particular vendor, or other third party, or benefits or services provided through a particular electronic

communications technology platform; provided, that nothing shall require an insurer to cover any electronic communications technology platform that does not comply with applicable state and federal privacy laws.

K. An insurer shall not place any restrictions on prescribing medications through telemedicine that are more restrictive than what is required under applicable state and federal law.

L. No later than January 1, 2023, the State Department of Health shall request a report from the Statewide Health Information Exchange that will provide the following data:

1. The number of providers using telehealth, including the location, frequency and specific services for which telehealth is utilized; and
2. The overall cost and cost savings associated with the utilization of telehealth services.



# OREGON

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Oregon

**Authorities: Or. Rev. Stat. §§§§ 743A.012, 743A.058, 743A.168, 743A.185**

## **Or. Rev. Stat. Ann. § 743A.012**

### *Emergency services covered*

(1) As used in this section:

(a) “Behavioral health assessment” means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient’s need for immediate crisis stabilization.

(b) “Behavioral health clinician” means:

(A) A licensed psychiatrist;

(B) A licensed psychologist;

(C) A licensed nurse practitioner with a specialty in psychiatric mental health;

(D) A licensed clinical social worker;

(E) A licensed professional counselor or licensed marriage and family therapist;

(F) A certified clinical social work associate;

(G) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or

(H) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

(c) “Behavioral health crisis” means a disruption in an individual’s mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual’s mental or physical health.

(d) “Emergency medical condition” means a medical condition:

(A) That manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:

(i) Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;

(ii) Result in serious impairment to bodily functions; or

(iii) Result in serious dysfunction of any bodily organ or part;

(B) With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child; or

(C) That is a behavioral health crisis.

(e) “Emergency medical screening exam” means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

(f) “Emergency medical service provider” has the meaning given that term in ORS 682.025.

(g) “Emergency medical services transport” means an emergency medical services provider’s evaluation and stabilization of an individual experiencing a medical emergency and the transportation of the individual to the nearest medical facility capable of meeting the needs of the individual.

(h) “Emergency services” means, with respect to an emergency medical condition:

(A) An emergency medical services transport;

(B) An emergency medical screening exam or behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(C) Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

(i) “Grandfathered health plan” has the meaning given that term in ORS 743B.005.

(j) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(k) "Prior authorization" has the meaning given that term in ORS 743B.001.

(L) "Stabilize" means to provide medical treatment as necessary to:

(A) Ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient to or from a facility; and

(B) With respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

(2) All insurers offering a health benefit plan shall provide coverage without prior authorization for emergency services.

(3) A health benefit plan, other than a grandfathered health plan, must provide coverage required by subsection (2) of this section:

(a) For the services of participating providers, without regard to any term or condition of coverage other than:

(A) The coordination of benefits;

(B) An affiliation period or waiting period permitted under part 7 of the Employee Retirement Income Security Act, part A of Title XXVII of the Public Health Service Act or chapter 100 of the Internal Revenue Code;

(C) An exclusion other than an exclusion of emergency services; or

(D) Applicable cost-sharing; and

(b) For the services of a nonparticipating provider:

(A) Without imposing any administrative requirement or limitation on coverage that is more restrictive than requirements or limitations that apply to participating providers;

(B) Without imposing a copayment amount or coinsurance rate that exceeds the amount or rate for participating providers;

(C) Without imposing a deductible, unless the deductible applies generally to nonparticipating providers; and

(D) Subject only to an out-of-pocket maximum that applies to all services from nonparticipating providers.

(4) All insurers offering a health benefit plan shall

provide information to enrollees in plain language regarding:

(a) What constitutes an emergency medical condition;

(b) The coverage provided for emergency services;

(c) How and where to obtain emergency services; and

(d) The appropriate use of 9-1-1.

(5) An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and may not deny coverage for emergency services when 9-1-1 is used.

(6) This section is exempt from ORS 743A.001.

### **Or. Rev. Stat. § 743A.058**

#### *Coverage of health service provided using telemedicine*

(1) As used in this section:

(a)(A) "Audio only" means the use of audio telephone technology, permitting real-time communication between a health care provider and a patient for the purpose of diagnosis, consultation or treatment.

(B) "Audio only" does not include:

(i) The use of facsimile, electronic mail or text messages.

(ii) The delivery of health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care provider, such as the sharing of laboratory results.

(b) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(c) "Health professional" means a person licensed, certified or registered in this state to provide health care services or supplies.

(d) "Health service" means physical, oral and behavioral health treatment or service provided by a health professional.

(e) "Originating site" means the physical location of the patient.

(f) "State of emergency" includes:

(A) A state of emergency declared by the Governor under ORS 401.165; or

(B) A state of public health emergency declared by the Governor under ORS 433.441.

(g) "Telemedicine" means the mode of delivering health services using information and telecommunication technologies to provide

consultation and education or to facilitate diagnosis, treatment, care management or self-management of a patient's health care.

(2) A health benefit plan and a dental-only plan must provide coverage of a health service that is provided using telemedicine if:

(a) The plan provides coverage of the health service when provided in person by a health professional;

(b) The health service is medically necessary;

(c) The health service is determined to be safely and effectively provided using telemedicine according to generally accepted health care practices and standards; and

(d) 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.

(3) Except as provided in subsection (4) of this section, permissible telemedicine applications and technologies include:

(a) Landlines, wireless communications, the Internet and telephone networks; and

(b) Synchronous or asynchronous transmissions using audio only, video only, audio and video and transmission of data from remote monitoring devices.

(4) During a state of emergency, a health benefit plan or dental-only plan shall provide coverage of a telemedicine service delivered to an enrollee residing in the geographic area specified in the declaration of the state of emergency, if the telemedicine service is delivered using any commonly available technology, regardless of whether the technology meets all standards required by state and federal laws governing the privacy and security of protected health information.

(5) A health benefit plan and a dental-only plan may not:

(a) Distinguish between rural and urban originating sites in providing coverage under subsection (2) of this section or restrict originating sites that qualify for reimbursement.

(b) Restrict a health care provider to delivering services only in person or only via telemedicine.

(c) Use telemedicine health care providers to meet network adequacy standards under ORS 743B.505.

(d) Require an enrollee to have an established patient-provider relationship with a provider to receive telemedicine health services from the provider or require an enrollee to consent to telemedicine services in person.

(e) Impose additional certification, location or training requirements for telemedicine providers or restrict the scope of services that may be provided using telemedicine to less than a provider's permissible scope of practice.

(f) Impose more restrictive requirements for telemedicine applications and technologies than those specified in subsection (3) of this section.

(g) Impose on telemedicine health services different annual dollar maximums or prior authorization requirements than the annual dollar maximums and prior authorization requirements imposed on the services if provided in person.

(h) Require a medical assistant or other health professional to be present with an enrollee at the originating site.

(i) Deny an enrollee the choice to receive a health service in person or via telemedicine.

(j) Reimburse an out-of-network provider at a rate for telemedicine health services that is different than the reimbursement paid to the out-of-network provider for health services delivered in person.

(k) Restrict a provider from providing telemedicine services across state lines if the services are within the provider's scope of practice and:

(A) The provider has an established practice within this state;

(B) The provider's employer operates health clinics or licensed health care facilities in this state;

(C) The provider has an established relationship with the patient; or

(D) The patient was referred to the provider by the patient's primary care or specialty provider located in this state.

(L) Prevent a provider from prescribing, dispensing or administering drugs or medical supplies or otherwise providing treatment recommendations to an enrollee after having performed an appropriate examination of the enrollee in person, through telemedicine or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically.

(m) Establish standards for determining medical necessity for services delivered using telemedicine that are higher than standards for determining medical necessity for services delivered in person.

(6) A health benefit plan and a dental-only plan shall:

(a) Work with contracted providers to ensure meaningful access to telemedicine services by assessing an enrollee's capacity to use telemedicine technologies that comply with accessibility standards, including alternate formats, and providing the optimal quality of care for the enrollee given the enrollee's capacity;

(b) Ensure access to auxiliary aids and services to ensure that telemedicine services accommodate the needs of enrollees who have difficulty communicating due to a medical condition, who need an accommodation due to disability or advanced age or who have limited English proficiency;

(c) Ensure access to telemedicine services for enrollees who have limited English proficiency or who are deaf or hard-of-hearing by providing interpreter services reimbursed at the same rate as interpreter services provided in person; and

(d) Ensure that telemedicine services are culturally and linguistically appropriate and trauma-informed.

(7) The coverage under subsection (2) of this section is subject to:

(a) The terms and conditions of the health benefit plan or dental-only plan; and

(b) Subject to subsection (8) of this section, the reimbursement specified in the contract between the plan and the health professional.

(8)(a) A health benefit plan and dental-only plan must pay the same reimbursement for a health service regardless of whether the service is provided in person or using any permissible telemedicine application or technology.

(b) Paragraph (a) of this subsection does not prohibit the use of value-based payment methods, including capitated, bundled, risk-based or other value-based payment methods, and does not require that any value-based payment method reimburse telemedicine health services based on an equivalent fee-for-service rate.

(9) This section does not require a health benefit plan or dental-only plan to reimburse a health professional:

(a) For a health service that is not a covered benefit under the plan;

(b) Who has not contracted with the plan; or

(c) For a service that is not included within the Healthcare Procedure Coding System or the American Medical Association's Current Procedural Terminology codes or related modifier codes.

(10) This section is exempt from ORS 743A.001.

### **Or. Rev. Stat. Ann. § 743A.168**

*Coverage for treatment of chemical dependency and for mental or nervous conditions*

(1) As used in this section:

(a) "Behavioral health assessment" means an evaluation by a provider, in person or using telemedicine, to determine a patient's need for behavioral health treatment.

(b) "Behavioral health condition" has the meaning prescribed by rule by the Department of Consumer and Business Services.

(c) "Behavioral health crisis" means a disruption in an insured's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the insured's mental or physical health.

(d) "Facility" means a corporate or governmental entity or other provider of services for the treatment of behavioral health conditions.

(e) "Generally accepted standards of care" means:

(A) Standards of care and clinical practice guidelines that:

(i) Are generally recognized by health care providers practicing in relevant clinical specialties; and

(ii) Are based on valid, evidence-based sources; and

(B) Products and services that:

(i) Address the specific needs of a patient for the purpose of screening for, preventing, diagnosing, managing or treating an illness, injury or condition or symptoms of an illness, injury or condition;

(ii) Are clinically appropriate in terms of type, frequency, extent, site and duration; and

(iii) Are not primarily for the economic benefit of an insurer or payer or for the convenience of a patient, treating physician or other health care provider.



(f) “Group health insurer” means an insurer, a health maintenance organization or a health care service contractor.

(g) “Median maximum allowable reimbursement rate” means the median of all maximum allowable reimbursement rates, minus incentive payments, paid for each billing code for each provider type during a calendar year.

(h) “Prior authorization” has the meaning given that term in ORS 743B.001.

(i) “Program” means a particular type or level of service that is organizationally distinct within a facility.

(j) “Provider” means:

(A) A behavioral health professional or medical professional licensed or certified in this state who has met the credentialing requirement of a group health insurer or an issuer of an individual health benefit plan that is not a grandfathered health plan as defined in ORS 743B.005 and is otherwise eligible to receive reimbursement for coverage under the policy;

(B) A health care facility as defined in ORS 433.060;

(C) A residential facility as defined in ORS 430.010;

(D) A day or partial hospitalization program;

(E) An outpatient service as defined in ORS 430.010; or

(F) A provider organization certified by the Oregon Health Authority under subsection (9) of this section.

(k) “Relevant clinical specialties” includes but is not limited to:

(A) Psychiatry;

(B) Psychology;

(C) Clinical sociology;

(D) Addiction medicine and counseling; and

(E) Behavioral health treatment.

(l) “Standards of care and clinical practice guidelines” includes but is not limited to:

(A) Patient placement criteria;

(B) Recommendations of agencies of the federal government; and

(C) Drug labeling approved by the United States Food and Drug Administration.

(m) “Utilization review” has the meaning given that term in ORS 743B.001.

(n) “Valid, evidence-based sources” includes but is not limited to:

(A) Peer-reviewed scientific studies and medical literature;

(B) Recommendations of nonprofit health care provider professional associations; and

(C) Specialty societies.

(2) A group health insurance policy or an individual health benefit plan that is not a grandfathered health plan providing coverage for hospital or medical expenses, other than limited benefit coverage, shall provide coverage for expenses arising from the diagnosis of behavioral health conditions and medically necessary behavioral health treatment at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for behavioral health treatment:

(a) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to copayments, deductibles and coinsurance. Copayments, deductibles and coinsurance for treatment in health care facilities or residential facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Copayments, deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

(b) The coverage of behavioral health treatment may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses of behavioral health treatment may be limited to treatment that is medically necessary as determined in accordance with this section and no more stringently under the policy than for other medical conditions.

(c) The coverage of behavioral health treatment must include:

(A) A behavioral health assessment;

(B) No less than the level of services determined to be medically necessary in a behavioral health assessment of the specific needs of a patient or in a patient’s care plan:

- (i) To effectively treat the patient's underlying behavioral health condition rather than the mere amelioration of current symptoms such as suicidal ideation or psychosis; and
  - (ii) For care following a behavioral health crisis, to transition the patient to a lower level of care;
  - (C) Treatment of co-occurring behavioral health conditions or medical conditions in a coordinated manner;
  - (D) Treatment at the least intensive and least restrictive level of care that is safe and most effective and meets the needs of the insured's condition;
  - (E) A lower level or less intensive care only if it is comparably as safe and effective as treatment at a higher level of service or intensity;
  - (F) Treatment to maintain functioning or prevent deterioration;
  - (G) Treatment for an appropriate duration based on the insured's particular needs;
  - (H) Treatment appropriate to the unique needs of children and adolescents;
  - (I) Treatment appropriate to the unique needs of older adults; and
  - (J) Coordinated care and case management as defined by the Department of Consumer and Business Services by rule.
- (d) The coverage of behavioral health treatment may not limit coverage for treatment of pervasive or chronic behavioral health conditions to short-term or acute behavioral health treatment at any level of care or placement.
- (e) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan shall have a network of providers of behavioral health treatment sufficient to meet the standards described in ORS 743B.505. If there is no in-network provider qualified to timely deliver, as defined by rule, medically necessary behavioral treatment to an insured in a geographic area, the group health insurer or issuer of an individual health benefit plan shall provide coverage of out-of-network medically necessary behavioral health treatment without any additional out-of-pocket costs if provided by an available out-of-network provider that enters into an agreement with the insurer to be reimbursed at in-network rates.

- (f) A provider is eligible for reimbursement under this section if:
- (A) The provider is approved or certified by the Oregon Health Authority;
  - (B) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities;
  - (C) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or
  - (D) The provider is providing a covered benefit under the policy.
- (g) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan must use the same methodology to set reimbursement rates paid to behavioral health treatment providers that the group health insurer or issuer of an individual health benefit plan uses to set reimbursement rates for medical and surgical treatment providers.
- (h) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan must update the methodology and rates for reimbursing behavioral health treatment providers in a manner equivalent to the manner in which the group health insurer or issuer of an individual health benefit plan updates the methodology and rates for reimbursing medical and surgical treatment providers, unless otherwise required by federal law.
- (i) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan that reimburses out-of-network providers for medical or surgical services must reimburse out-of-network behavioral health treatment providers on the same terms and at a rate that is in parity with the rate paid to medical or surgical treatment providers.
- (j) Outpatient coverage of behavioral health treatment shall include follow-up in-home service or outpatient services if clinically indicated under criteria and guidelines described in subsection (5) of this section. The policy may limit coverage for in-home service to persons who are homebound under the care of a physician only if clinically indicated under criteria and guidelines described in subsection (5) of this section.
- (k)(A) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230

relating to psychologists, ORS 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer or issuer of an individual health benefit plan may provide for review for level of treatment of admissions and continued stays for treatment in health facilities, residential facilities, day or partial hospitalization programs and outpatient services by either staff of a group health insurer or issuer of an individual health benefit plan or personnel under contract to the group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

(B) Review shall be made according to criteria made available to providers in advance upon request.

(C) Review shall be performed by or under the direction of a physician licensed under ORS 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social worker licensed by the State Board of Licensed Social Workers or a professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.

(D) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, group health insurers and issuers of individual health benefit plans that are not grandfathered health plans shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers and issuers of individual health benefit plans that are not grandfathered health plans shall provide a timely response to such inquiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

(L) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers contracting

with the health maintenance organization. Health maintenance organizations and health care service contractors may create substantive plan benefit and reimbursement differentials at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other medical conditions and apply them to contracting and noncontracting providers.

(3) This section does not prohibit a group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (2)(b) of this section provided such methods comply with the requirements of this section.

(4) The Legislative Assembly finds that health care cost containment is necessary and intends to encourage health insurance plans designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into the insurance, either directly or by reference, in accordance with this section.

(5)(a) Any medical necessity, utilization or other clinical review conducted for the diagnosis, prevention or treatment of behavioral health conditions or relating to service intensity, level of care placement, continued stay or discharge must be based solely on the following:

(A) The current generally accepted standards of care.

(B) For level of care placement decisions, the most recent version of the levels of care placement criteria developed by the nonprofit professional association for the relevant clinical specialty.

(C) For medical necessity, utilization or other clinical review conducted for the diagnosis, prevention or treatment of behavioral health conditions that does not involve level of care placement decisions, other criteria and guidelines may be utilized if such criteria and guidelines are based on the current generally accepted standards of care including valid, evidence-based sources and current treatment criteria or practice guidelines developed by the nonprofit professional association for the relevant clinical specialty. Such other criteria and guidelines must be made publicly available and made available to

insureds upon request to the extent permitted by copyright laws.

(b) This subsection does not prevent a group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan from using criteria that:

(A) Are outside the scope of criteria and guidelines described in paragraph (a)(B) of this subsection, if the guidelines were developed in accordance with the current generally accepted standards of care; or

(B) Are based on advancements in technology of types of care that are not addressed in the most recent versions of sources specified in paragraph (a)(B) of this subsection, if the guidelines were developed in accordance with current generally accepted standards of care.

(c) For all level of care placement decisions, an insurer shall authorize placement at the level of care consistent with the insured's score or assessment using the relevant level of care placement criteria and guidelines as specified in paragraph (a)(B) of this subsection. If the level of care indicated by the criteria and guidelines is not available, the insurer shall authorize the next higher level of care. If there is disagreement about the appropriate level of care, the insurer shall provide to the provider of the service the full details of the insurer's scoring or assessment using the relevant level of care placement criteria and guidelines specified in paragraph (a)(B) of this subsection.

(6) To ensure the proper use of any criteria and guidelines described in subsection (5) of this section, a group health insurer or an issuer of an individual health benefit plan shall provide, at no cost:

(a) A formal education program, presented by nonprofit clinical specialty associations or other entities authorized by the department, to educate the insurer's or the issuer's staff and any individuals described in subsection (2)(k) of this section who conduct reviews.

(b) To stakeholders, including participating providers and insureds, the criteria and guidelines described in subsection (5) of this section and any education or training materials or resources regarding the criteria and guidelines.

(7) This section does not prevent a group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan from contracting with providers of health care services to

furnish services to policyholders or certificate holders according to ORS 743B.460 or 750.005, subject to the following conditions:

(a) A group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan is not required to contract with all providers that are eligible for reimbursement under this section.

(b) An insurer or health care service contractor shall, subject to subsection (2) of this section, pay benefits toward the covered charges of noncontracting providers of services for behavioral health treatment. The insured shall, subject to subsection (2) of this section, have the right to use the services of a noncontracting provider of behavioral health treatment, whether or not the behavioral health treatment is provided by contracting or noncontracting providers.

(8)(a) This section does not require coverage for:

(A) Educational or correctional services or sheltered living provided by a school or halfway house;

(B) A long-term residential mental health program that lasts longer than 45 days unless clinically indicated under criteria and guidelines described in subsection (5) of this section;

(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;

(D) A court-ordered sex offender treatment program; or

(E) Support groups.

(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation.

(9) The Oregon Health Authority shall establish a process for the certification of an organization described in subsection (1)(j)(F) of this section that:

(a) Is not otherwise subject to licensing or certification by the authority; and

(b) Does not contract with the authority, a subcontractor of the authority or a community mental health program.

(10) The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection (9) of this section to ensure that a certified

provider organization offers a distinct and specialized program for the treatment of mental or nervous conditions.

(11) The Oregon Health Authority may adopt by rule an application fee or a certification fee, or both, to be imposed on any provider organization that applies for certification under subsection (9) of this section. Any fees collected shall be paid into the Oregon Health Authority Fund established in ORS 413.101 and shall be used only for carrying out the provisions of subsection (9) of this section.

(12) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to ensure continuing access to levels of care most appropriate for the insured's condition and progress in accordance with this section. This section does not prohibit an insurer from requiring a provider organization certified by the Oregon Health Authority under subsection (9) of this section to meet the insurer's credentialing requirements as a condition of entering into a contract.

(13) The Director of the Department of Consumer and Business Services and the Oregon Health Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of this section. The director shall adopt rules making it a violation of this section for a group health insurer or issuer of an individual health benefit plan other than a grandfathered health plan to require providers to bill using a specific billing code or to restrict the reimbursement paid for particular billing codes other than on the basis of medical necessity.

(14) This section does not:

(a) Prohibit an insured from receiving behavioral health treatment from an out-of-network provider or prevent an out-of-network behavioral health provider from billing the insured for any unreimbursed cost of treatment.

(b) Prohibit the use of value-based payment methods, including global budgets or capitated, bundled, risk-based or other value-based payment methods.

(c) Require that any value-based payment method reimburse behavioral health services based on an equivalent fee-for-service rate.

## **Or. Rev. Stat. § 743A.185**

*Health benefit plans; diabetes; telemedical health service coverage*

(1) As used in this section:

(a) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(b) "Originating site" means a location where health services are provided or where the patient is receiving a telemedical health service.

(c) "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.

(2) A health benefit plan must provide coverage of a telemedical health service provided in connection with the treatment of diabetes if:

(a) The plan provides coverage of the health service when provided in person by the health professional;

(b) The health service is medically necessary;

(c) The telemedical health service relates to a specific patient; and

(d) One of the participants in the telemedical health service is a representative of an academic health center.

(3) A health benefit plan may not distinguish between rural and urban originating sites in providing coverage under subsection (2) of this section.

(4) A health benefit plan may subject coverage of a telemedical health service under subsection (2) of this section 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.

(5) This section does not require a health benefit plan to reimburse a provider for a health service that is not a covered benefit under the plan.

# PENNSYLVANIA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Pennsylvania

There are currently no commercial payer telehealth statutes in this state.



# RHODE ISLAND

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A





# Rhode Island



**Authorities: R.I. Gen. Laws §§ 27-81-3, 27-81-4**

## **R.I. Gen. Laws § 27-81-3**

### *Definitions*

As used in this chapter:

- (1) “Clinically appropriate” means care that is delivered in the appropriate medical setting.
- (2) “Distant site” means a site at which a healthcare provider is located while providing healthcare services by means of telemedicine.
- (3) “Healthcare facility” means an institution providing healthcare services or a healthcare setting, including, but not limited to: hospitals and other licensed, inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory and imaging centers; and rehabilitation and other therapeutic-health settings.
- (4) “Healthcare professional” means a physician or other healthcare practitioner licensed, accredited, or certified to perform specified health-care services consistent with state law.
- (5) “Healthcare provider” means a healthcare professional or a healthcare facility.
- (6) “Healthcare services” means any services included in the furnishing to any individual of medical, podiatric, or dental care, or hospitalization, or incident to the furnishing of that care or hospitalization, and the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.
- (7) “Health insurer” means any person, firm, or corporation offering and/or insuring healthcare services on a prepaid basis, including, but not limited to, a nonprofit service corporation, a health-maintenance organization, the Rhode Island Medicaid program, including its contracted managed care entities, or an entity offering a policy of accident and sickness insurance.
- (8) “Health-maintenance organization” means a health-maintenance organization as defined in chapter 41 of this title.
- (9) “Medically necessary” means medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of a health-related condition, including services necessary to prevent a decremental change in either medical or mental health status.
- (10) “Nonprofit service corporation” means a nonprofit, hospital service corporation as defined in chapter 19 of this title, or a nonprofit, medical-service corporation as defined in chapter 20 of this title.
- (11) “Originating site” means a site at which a patient is located at the time healthcare services are provided to them by means of telemedicine, which can include a patient’s home where medically necessary and clinically appropriate.
- (12) “Policy of accident and sickness insurance” means a policy of accident and sickness insurance as defined in chapter 18 of this title.
- (13) “Rhode Island Medicaid program” means a state-administered, medical assistance program that is funded by the state and federal governments under Title XIX and Title XXI of the U.S. Social Security Act and any general or public laws and administered by the executive office of health and human services.
- (14) “Store-and-forward technology” means the technology used to enable the transmission of a patient’s medical information from an originating site to the healthcare provider at the distant site without the patient being present.
- (15) “Telemedicine” means the delivery of clinical healthcare services by use of real time, two-way synchronous audio, video, telephone-audio-only communications or electronic media or other telecommunications technology including, but not limited to: online adaptive interviews, remote patient



monitoring devices, audiovisual communications, including the application of secure video conferencing or store-and-forward technology to provide or support healthcare delivery, which facilitate assessment, diagnosis, counseling and prescribing treatment, and care management of a patient's health care while such patient is at an originating site and the healthcare provider is at a distant site, consistent with applicable federal laws and regulations.

"Telemedicine" does not include an 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.

### **R.I. Gen. Laws § 27-81-4**

#### *Coverage of telemedicine services*

(a) Each health insurer that issues individual or group accident and sickness insurance policies for healthcare services and/or provides a healthcare plan for healthcare services shall provide coverage for the cost of such covered healthcare services provided through telemedicine services, as provided in this section.

(b)(1) A health insurer shall not exclude a healthcare service for coverage solely because the healthcare service is provided through telemedicine and is not provided through in-person consultation or contact, so long as such healthcare services are medically necessary and clinically appropriate to be provided through telemedicine services.

(2) All medically necessary and clinically appropriate telemedicine services delivered by in-network primary care providers, registered dietitian nutritionists, and behavioral health providers shall be reimbursed at

rates not lower than services delivered by the same provider through in-person methods.

(c) Benefit plans offered by a health insurer shall not impose a deductible, copayment or coinsurance requirement for a healthcare service delivered through telemedicine in excess of what would normally be charged for the same healthcare service when performed in person.

(d) Prior authorization requirements for medically necessary and clinically appropriate telemedicine services shall not be more stringent than prior authorization requirements for in-person care. No more stringent medical or benefit determination and utilization review requirements shall be imposed on any telemedicine service than is imposed upon the same service when performed in person.

(e) Except for requiring compliance with applicable state and federal laws, regulations, and/or guidance, no health insurer shall impose any specific requirements as to the technologies used to deliver medically necessary and clinically appropriate telemedicine services.

(f) The requirements of this section shall apply to all policies and health plans issued, reissued or delivered in the state of Rhode Island on and after January 1, 2018.

(g) This chapter shall not apply to: short-term travel, accident-only, limited or specified disease; or individual conversion policies or health plans; nor to policies or health plans designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare; or any other similar coverage under state or federal governmental plans.

# SOUTH CAROLINA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# South Carolina

There are currently no commercial payer telehealth statutes in this state.



## SOUTH DAKOTA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# South Dakota



**Authorities: S.D. Codified Laws §§ 58-17-167, -168, -169, -170**

## **S.D. Codified Laws § 58-17-167**

### *Definitions pertaining to telehealth coverage*

Terms used in §§ 58-17-167 to 58-17-170, inclusive, mean:

- (1) “Health care professional,” as defined in § 58-17F-1;
- (2) “Health care services,” as defined in § 58-17F-1;
- (3) “Health insurer,” as defined in § 58-17-100;
- (4) “Telehealth,” the delivery of health care services through the use of HIPAA-compliant interactive audio-video. The term does not include the delivery of health care services through audio-only telephone, electronic mail message, text message, mail service, facsimile transmission, or any combination thereof.

## **S.D. Codified Laws § 58-17-168**

### *Coverage for health care services provided through telehealth*

No health insurer may exclude a service for coverage solely because the service is provided through telehealth and not provided through in-person consultation or contact between a health care professional and a patient. Health care services delivered by telehealth must be appropriate and delivered in accordance with applicable law and generally accepted health care practices and standards prevailing at the time the health care services are provided, including rules adopted by the appropriate professional licensing board having oversight of the health care professional providing the health care services. Health insurers are not required to provide coverage for health care services that are not medically necessary.

This section does not:

- (1) Prohibit a health insurer from establishing criteria that a health care professional must meet to demonstrate the safety and efficacy of delivering a particular health care service via telehealth that the

health insurer does not already reimburse other health care professionals for delivering via telehealth so long as the criteria are not unduly burdensome or unreasonable for the particular services;

- (2) Prevent a health insurer from requiring a health care professional to agree to certain documentation or billing practices designed to protect the health insurer or patients from fraudulent claims so long as the practices are not unduly burdensome or unreasonable for the particular services; or

- (3) Prevent a health insurer from including a deductible, copayment, or coinsurance requirement for a health care service provided via telehealth, if the deductible, copayment, or coinsurance is not in addition to and does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through in-person contact.

## **S.D. Codified Laws § 58-17-169**

### *Discrimination between coverage for services provided in person and through telehealth prohibited*

A health insurance policy, contract, or plan providing for third-party payment may not discriminate between coverage benefits for health care services that are provided in person and the same health care services that are delivered through telehealth as long as the services are appropriate to be provided through telehealth. Nothing in §§ 58-17-167 to 58-17-170, inclusive, prohibits a health insurer and a health care professional from entering into a contract for telehealth with terms subject to negotiation.

## **S.D. Codified Laws § 58-17-170**

### *Application of telehealth coverage requirements*

The requirements of §§ 58-17-168 and 58-17-169 apply to any health insurer offering any individual or group health insurance policy, contract, certificate, or plan delivered, issued for delivery, or renewed in South Dakota on or after January 1, 2020. The







requirements of §§ 58-17-168 and 58-17-169 do not apply to any plan, policy, or contract providing coverage only for:

- (1) Specified disease;
- (2) Hospital indemnity;
- (3) Fixed indemnity;
- (4) Accident-only;
- (5) Credit accident and health insurance;
- (6) Vision;
- (7) Prescription drug;
- (8) Medicare supplement;
- (9) Long-term care;
- (10) Disability income insurance;
- (11) Coverage issued as a supplement to liability insurance;
- (12) Workers' compensation or similar insurance;
- (13) Automobile medical payment insurance; or
- (14) Individual health benefit plans of six-months or less duration that are not renewable.

The requirements of §§ 58-17-168 and 58-17-169 do not apply to services offered that are not part of the policy, contract, certificate, or plan offered and for which there is no premium charged.

## TENNESSEE

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Tennessee



**Authorities: Tenn. Code §§ 56-7-1002, -1003, -1011, -1012**

## **Tenn. Code § 56-7-1002**

*Health and Accident Insurance—Healthcare services delivered through telehealth encounter*

(a) As used in this section:

(1) “Health insurance entity” has the same meaning as defined in § 56-7-109 and includes managed care organizations participating in the medical assistance program under title 71, chapter 5;

(2) “Healthcare services” has the same meaning as defined in § 56-61-102;

(3) “Healthcare services provider” means 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;

(4) “Originating site” means the location where a patient is located pursuant to subdivision (a)(7)(A) and that originates a telehealth service to another qualified site;

(5) “Qualified site” means the office of a healthcare services provider, a hospital licensed under title 68, a facility recognized as a rural health clinic under federal Medicare regulations, a federally qualified health center, any facility licensed under title 33, or any other location deemed acceptable by the health insurance entity;

(6) “Store-and-forward telemedicine services”:

(A) Means the use of 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

(B) Includes 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;

(7) “Telehealth”:

(A) Means the use of real-time, interactive audio,

video telecommunications or electronic technology, or store-and-forward telemedicine services by a healthcare services provider to deliver healthcare services to a patient within the scope of practice of the healthcare services provider when:

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

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

(B) Does not include:

(i) An audio-only conversation;

(ii) An electronic mail message; or

(iii) A facsimile transmission; and

(8) “Telehealth provider” means a healthcare services provider engaged in the delivery of healthcare services through telehealth.

(b) Healthcare services provided through a telehealth encounter shall comply with state licensure requirements promulgated by the appropriate licensure boards. Telehealth providers shall be held to the same standard of care as healthcare services providers providing the same healthcare service through in-person encounters.

(c) A telehealth provider who seeks to contract with or who has contracted with a health insurance entity to participate in the health insurance entity’s network shall be subject to the same requirements and contractual terms as a healthcare services provider in the health insurance entity’s network.

(d) Subject to subsection (c), a health insurance entity:

(1) Shall provide coverage under a health insurance policy or contract for covered healthcare services delivered through telehealth;

(2) Shall reimburse a healthcare services provider for the diagnosis, consultation, and treatment of an insured patient for a healthcare service covered under a health insurance policy or contract that is provided through telehealth without any distinction or consideration of the geographic location or any federal, state, or local designation, or classification of the geographic area where the patient is located;

(3) Shall not exclude from coverage a healthcare service solely because it is provided through telehealth and is not provided through an in-person encounter between a healthcare services provider and a patient; and

(4) Shall reimburse healthcare services providers who are out-of-network for telehealth care services under the same reimbursement policies applicable to other out-of-network healthcare services providers.

(e) 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, and shall reimburse for healthcare services provided during a telehealth encounter without 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.

(f) Deleted by 2020 Pub.Acts (2nd Ex. Sess.), c. 4, § 3, eff. Aug. 20, 2020.

(g) Any provisions not stipulated by this section shall be governed by the terms and conditions of the health insurance contract.

(h) Telehealth is subject to utilization review under the Health Care Service Utilization Review Act, compiled in chapter 6, part 7 of this title.

(i)(1) This section does not apply to accident-only, specified disease, hospital indemnity, plans described in § 1251 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended and § 2301 of the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, as amended (both in 42 U.S.C. § 18011), plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1001 et seq.), medicare supplement, disability income, long-term care, or other limited benefit hospital insurance policies.

(2) This section does apply to the basic health plans authorized under title 8, chapter 27, parts 1, 2, 3, and 7.

(j) A health insurance entity shall reimburse an originating site hosting a patient as part of a telehealth encounter an originating site fee in accordance with the federal centers for medicare and medicaid services telehealth services rule 42 C.F.R. § 410.78 and at an amount established prior to August 20, 2020, by the federal centers for medicare and medicaid services.

(k)(1) This section does not require a health insurance entity to provide coverage for healthcare services that are not medically necessary, unless the terms and conditions of an applicable health insurance policy provide that coverage.

(2) As used in subdivision (k)(1):

(A) For a healthcare service for which coverage or reimbursement is provided under the Medical Assistance Act of 1968, compiled in title 71, chapter 5, part 1, or provided under title 71, chapter 3, part 11, “medically necessary” means a healthcare service that is determined by the bureau of TennCare to satisfy the medical necessity standard set forth in 71-5-144; and

(B) For all other healthcare services, “medically necessary” means healthcare services that a healthcare services provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease, and that are:

(i) In accordance with generally accepted standards of medical practice;

(ii) Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the patient’s illness, injury or disease; and

(iii) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease excluding any costs paid pursuant to subsection (j).

(3) This section does not require a health insurance entity to provide coverage for healthcare services

delivered by means of telehealth if the applicable health insurance policy would not provide coverage for the same healthcare services if delivered by in-person means.

(4) This section does not require a health insurance entity to reimburse a healthcare services provider for healthcare services delivered by means of telehealth if the applicable health insurance policy would not reimburse that healthcare services provider if the same healthcare services had been delivered by in-person means

### **Tenn. Code § 56-7-1003**

*Health and Accident Insurance—Healthcare services provided through provider-based telemedicine*

(a) As used in this section:

(1) “Health insurance entity” has the same meaning as defined in § 56-7-109 and includes managed care organizations participating in the medical assistance program under title 71, chapter 5;

(2) “Healthcare services” has the same meaning as defined in § 56-61-102;

(3) “Healthcare services provider” means an individual acting within the scope of a valid license issued pursuant to title 63 or title 68, chapter 24, part 6, or any state-contracted crisis service provider employed by a facility licensed under title 33;

(4) “Healthcare system” means two (2) or more healthcare organizations as defined in § 63-1-150, that are affiliated through shared ownership or pursuant to a contractual relationship that controls payment terms and service delivery;

(5) “Practice group” means two (2) or more healthcare services providers that share a common employer for the purposes of the healthcare services providers’ clinical practice;

(6) “Provider-based telemedicine”:

(A) Means the use of Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. § 1320d et seq.) compliant real-time, interactive audio, video telecommunications, or electronic technology, or store-and-forward telemedicine services, used over the course of an interactive visit by a healthcare services provider to deliver healthcare services to a patient within the scope of practice of the healthcare services provider when:

(i) The healthcare services provider is at a qualified site other than the site where the patient is located and has access to the relevant medical record for that patient;

(ii) The patient is located at a location the patient deems appropriate to receive the healthcare service that is equipped to engage in the telecommunication described in this section; and

(iii) (a) The healthcare services provider makes use of HIPAA compliant real-time, interactive audio, video telecommunications or electronic technology, or store-and-forward telemedicine services to deliver healthcare services to a patient within the scope of practice of the healthcare services provider as long as the healthcare services provider, the healthcare services provider’s practice group, or the healthcare system has established a provider-patient relationship by submitting to a health insurance entity evidence of an in-person encounter between the healthcare service provider, the healthcare services provider’s practice group, or the healthcare system and the patient within sixteen (16) months prior to the interactive visit;

(b) The requirement of an in-person encounter between the healthcare services provider, the healthcare services provider’s practice group, or the healthcare system and the patient within sixteen (16) months prior to the interactive visit is tolled for the duration of a state of emergency declared by the governor pursuant to § 58-2-107; provided, that the healthcare services provider or the patient, or both, are located in the geographical area covered by the applicable state of emergency; and

(c) The requirement of an in-person encounter between the healthcare services provider, the healthcare services provider’s practice group, or the healthcare system and the patient within sixteen (16) months prior to the interactive visit does not apply to a patient who is receiving an initial behavioral health evaluation or assessment;

(B) Does not include:

(i) An audio-only conversation;

(ii) An electronic mail message or phone text message;

(iii) A facsimile transmission;

(iv) Remote patient monitoring; or

(v) Healthcare services provided pursuant to a

contractual relationship between a health insurance entity and an entity that facilitates the delivery of provider-based telemedicine as the substantial portion of the entity's business; and

(C) Notwithstanding subdivisions (a)(6)(A) and (B), includes Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. § 1320d et seq.) compliant audio-only conversation for the provision of:

(i) Behavioral health services when the means described in subdivision (a)(6)(A) are unavailable; and

(ii) Healthcare services when the means described in subdivision (a)(6)(A) are unavailable;

(7) "Qualified site" means the primary or satellite office of a healthcare services provider, a hospital licensed under title 68, a facility recognized as a rural health clinic under federal medicare regulations, a federally qualified health center, a facility licensed under title 33, or any other location deemed acceptable by the health insurance entity; and

(8) "Store-and-forward telemedicine services":

(A) Means the use of 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

(B) Includes 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.

(b) Healthcare services provided through a provider-based telemedicine encounter must comply with state licensure requirements promulgated by the appropriate licensure boards. Provider-based telemedicine providers are held to the same standard of care as healthcare services providers providing the same healthcare services through in-person encounters.

(c) A provider-based telemedicine provider who seeks to contract with or who has contracted with a health insurance entity to participate in the health insurance entity's network is subject to the same requirements and contractual terms as any other healthcare services provider in the health insurance entity's network.

(d) A health insurance entity:

(1) Shall provide coverage under a health insurance

policy or contract for covered healthcare services delivered through provider-based telemedicine;

(2) Shall reimburse a healthcare services provider for a healthcare service covered under an insured patient's health insurance policy or contract that is provided through provider-based telemedicine 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;

(3) Shall not exclude from coverage a healthcare service solely because it is provided through provider-based telemedicine and is not provided through an in-person encounter between a healthcare services provider and a patient; and

(4) Shall reimburse healthcare services providers who are out-of-network for provider-based telemedicine care services under the same reimbursement policies applicable to other out-of-network healthcare services providers.

(e) A health insurance entity shall provide coverage for healthcare services provided during a provider-based telemedicine encounter in a manner that is consistent with what the health insurance policy or contract provides for in-person encounters for the same service, and shall reimburse for healthcare services provided during a provider-based telemedicine encounter without 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.

(f) This section does not require a health insurance entity to pay total reimbursement for a provider-based telemedicine encounter in an amount that exceeds the amount that would be paid for the same service provided by a healthcare services provider for an in-person encounter.

(g)(1) This section does not require a health insurance entity to provide coverage for healthcare services that are not medically necessary, unless the terms and conditions of an applicable health insurance policy provide that coverage.

(2) As used in subdivision (g)(1):

(A) For a healthcare service for which coverage or reimbursement is provided under the Medical Assistance Act of 1968, compiled in title 71, chapter 5, part 1, or provided under title 71, chapter 3, part 11, "medically necessary" means a healthcare service

that is determined by the bureau of TennCare to satisfy the medical necessity standard set forth in 71-5-144; and

(B) For all other healthcare services, “medically necessary” means healthcare services that a healthcare services provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease, and that are:

(i) In accordance with generally accepted standards of medical practice;

(ii) Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the patient’s illness, injury or disease; and

(iii) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.

(3) This section does not require a health insurance entity to provide coverage for healthcare services delivered by means of provider-based telemedicine if the applicable health insurance policy would not provide coverage for the same healthcare services if delivered by in-person means.

(4) This section does not require a health insurance entity to reimburse a healthcare services provider for healthcare services delivered by means of provider-based telemedicine if the applicable health insurance policy would not reimburse that healthcare services provider if the same healthcare services had been delivered by in-person means.

(h) Any provisions not required by this section are governed by the terms and conditions of the health insurance policy or contract.

(i) Provider-based telemedicine is subject to utilization review under the Health Care Service Utilization Review Act, compiled in chapter 6, part 7 of this title.

(j)(1) This section does not apply to accident-only, specified disease, hospital indemnity, plans described in § 1251 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended and § 2301 of the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, as amended (both in 42 U.S.C. § 18011), plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1001 et seq.), medicare supplement,

disability income, long-term care, or other limited benefit hospital insurance policies.

(2) This section does apply to the basic health plans authorized under title 8, chapter 27, parts 1, 2, 3, and 7.

(k) A healthcare provider, office staff, or party acting on behalf of the healthcare provider submitting for reimbursement of an audio-only encounter under subdivision (a)(6)(C)(ii) shall:

(1) Confirm and maintain documentation that the patient:

(A) Does not own the video technology necessary to complete an audio-video provider-based telemedicine encounter;

(B) Is at a location where an audio-video encounter cannot take place due to lack of service; or

(C) Has a physical disability that inhibits the use of video technology; and

(2) Notify the patient that the financial responsibility for the audio-only encounter will be consistent with the financial responsibility for other in-person or video encounters, prior to the audio-only telemedicine encounter.

### **Tenn. Code § 56-7-1011**

#### *Health and Accident Insurance—Remote patient monitoring services*

(a) As used in this section, “remote patient monitoring services” means using digital technologies to collect medical and other forms of health data from a patient and then electronically transmitting that information securely to healthcare providers in a different location for interpretation and recommendation.

(b) A health insurance entity may consider any remote patient monitoring service a covered medical service if the same service is covered by medicare. The appropriate parties may negotiate the rate for these services in the manner in which is deemed appropriate by the parties.

(c) Reimbursement of expenses for covered remote patient monitoring services must be established through negotiations conducted by the health insurance entity with the healthcare services provider, healthcare system, or practice group in the same manner as the health insurance entity establishes reimbursement of expenses for covered healthcare services that are delivered by in-person means.





(d) Remote patient monitoring services are subject to utilization review under the Health Care Service Utilization Review Act, compiled in chapter 6, part 7 of this title.

(e) This section does not apply to a health incentive program operated by a health insurance entity that utilized an electronic device for physiological monitoring.

**Tenn. Code § 56-7-1012 (to be repealed on April 1, 2022)**

*Health and Accident Insurance—Reimbursement for healthcare provided through telehealth encounter*

(a) Notwithstanding § 56-7-1002(e), a health insurance entity shall provide reimbursement 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, and shall reimburse for healthcare services provided during a telehealth encounter without 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.

(b) Notwithstanding § 56-7-1003(e), a health insurance entity shall provide reimbursement for healthcare services provided during a provider-based telemedicine encounter in a manner that is consistent with what the health insurance policy or contract provides for in-person encounters for the same service, and shall reimburse for healthcare services provided during a provider-based telemedicine encounter without 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.

(c) Reimbursement made pursuant to this section is subject to utilization review under the Health Care Service Utilization Review Act, compiled in title 56, chapter 6, part 7.

(d)(1) This section does not require a health insurance entity to provide reimbursement for healthcare services that are not medically necessary, unless the terms and conditions of an applicable health insurance policy provide that coverage.

(2) As used in this subsection (d):

(A) For a healthcare service for which coverage or reimbursement is provided under the Medical

Assistance Act of 1968, compiled in title 71, chapter 5, part 1, or provided under title 71, chapter 3, part 11, “medically necessary” means a healthcare service that is determined by the bureau of TennCare to satisfy the medical necessity standard set forth in § 71-5-144; and

(B) For all other healthcare services, “medically necessary” means healthcare services that a healthcare services provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease, and that are:

(i) In accordance with generally accepted standards of medical practice;

(ii) Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the patient’s illness, injury or disease; and

(iii) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

(e) This section does not require a healthcare services provider to seek reimbursement from a health insurance entity for healthcare services provided by telehealth or provider-based telemedicine.

(f) For the purposes of this section:

(1) “Health insurance entity” has the same meaning as defined in § 56-7-109 and includes managed care organizations participating in the medical assistance program under title 71, chapter 5;

(2) “Healthcare services” has the same meaning as defined in § 56-61-102;

(3) “Healthcare services provider” means an individual acting within the scope of a valid license issued pursuant to title 63 or title 68, chapter 24, part 6, or any state-contracted crisis service provider employed by a facility licensed under title 33;

(4) “Provider-based telemedicine” has the same meaning as defined in § 56-7-1003; and

(5) “Telehealth” has the same meaning as defined in § 56-7-1002.

(g) Deleted by 2022 Pub.Acts, c. 766, § 1, eff. April 1, 2022.

## TEXAS

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A

FPO

# Texas

**Authorities: Tex. Ins. Code §§ 1455.001–1455.004, 1455.006; Tex. Occ. Code § 111.001**

## Tex. Ins. Code § 1455.001

### *Definitions*

In this chapter:

(1) “Dentist” means a person licensed to practice dentistry in this state under Subtitle D, Title 3, Occupations Code.

(1-a) “Health professional” means:

(A) a physician;

(B) an individual who is:

(i) licensed or certified in this state to perform health care services; and

(ii) authorized to assist

(a) a physician in providing telemedicine medical services that are delegated and supervised by the physician; or

(b) a dentist in providing teledentistry dental services that are delegated and supervised by the dentist;

(C) a licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service or a teledentistry dental service; or

(D) a dentist.

(2) “Physician” means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.<sup>1</sup>

(2-a) “Platform” means the technology, system, software, application, modality, or other method through which a health professional remotely interfaces with a patient when providing a health care service or procedure as a telemedicine medical service or telehealth service.

(3) “Teledentistry dental service,” “telehealth service,” and “telemedicine medical service” have the meanings assigned by Section 111.001, Occupations Code.

## Tex. Ins. Code § 1455.002

### *Applicability of Chapter*

This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

## Tex. Ins. Code § 1455.003

### *Exception*

This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

- (B) only for accidental death or dismemberment;
- (C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or
- (D) as a supplement to a liability insurance policy;
- (2) a small employer health benefit plan written under Chapter 1501;
- (3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (4) a workers' compensation insurance policy;
- (5) medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1455.002.

**Tex. Ins. Code § 1455.004**

*Coverage for Telemedicine Medical Services and Telehealth Services*

- (a) A health benefit plan:
  - (1) must provide coverage for a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service or telehealth service on the same basis and to the same extent that the plan provides coverage for the service or procedure in an in-person setting; and
  - (2) may not:
    - (A) exclude from coverage a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service, a teledentistry dental service, or a telehealth service solely because the covered health care service or procedure is not provided through an in-person consultation; and
    - (B) subject to Subsection (c), limit, deny, or reduce coverage for a covered health care service or procedure delivered as a telemedicine medical service or telehealth service based on the health professional's choice of platform for delivering the service or procedure.

(b) A health benefit plan may require a deductible, a copayment, or coinsurance for a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service or a telehealth service. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for the covered health care service or procedure provided through an in-person consultation.

(b-1) Subsection (b) does not authorize a health benefit plan to charge a separate deductible that applies only to a covered health care service or procedure delivered as a telemedicine medical service, teledentistry dental service, or telehealth service.

(c) Notwithstanding Subsection (a), a health benefit plan is not required to provide coverage for a telemedicine medical service, a teledentistry dental service, or a telehealth service provided by only synchronous or asynchronous audio interaction, including:

- (1) an audio-only telephone consultation;
- (2) a text-only e-mail message; or
- (3) a facsimile transmission.

(d) A health benefit plan may not impose an annual or lifetime maximum on coverage for covered health care services or procedures delivered as telemedicine medical services or telehealth services other than the annual or lifetime maximum, if any, that applies in the aggregate to all items and services and procedures covered under the plan.

**Tex. Ins. Code § 1455.006**

*Telemedicine Medical Services, Teledentistry Dental Services, and Telehealth Services Statement*

- (a) Each issuer of a health benefit plan shall adopt and display in a conspicuous manner on the health benefit plan issuer's Internet website the issuer's policies and payment practices for telemedicine medical services, teledentistry dental services, and telehealth services.
- (b) This section does not require an issuer of a health benefit plan to display negotiated contract payment rates for health professionals who contract with the issuer to provide telemedicine medical services, teledentistry dental services, or telehealth services.

## Tex. Occ. Code § 111.001

### *Definitions*

(1) “Dentist,” “health professional,” and “physician” have the meanings assigned by Section 1455.001, Insurance Code.

(2) “Store and forward technology” means technology that stores and transmits or grants access to a person’s clinical information for review by a health professional at a different physical location than the person.

(2-a) “Teledentistry dental service” means a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist’s or health professional’s license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

(3) “Telehealth service” means a health service, other than a telemedicine medical service or a teledentistry dental 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.

(4) “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.

## UTAH

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Utah

**Authorities: Utah Code §§ 31A-22-649.5, 31A-22-649, 26B-4-704**

## Utah Code § 31A-22-649.5

*Insurance parity for telemedicine services – Method of technology used*

(1) As used in this section:

(a) “Mental health condition” means a mental disorder or a substance-related disorder that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as periodically revised.

(b) “Telemedicine services” means the same as that term is defined in Section 26B-4-704.

(2) Notwithstanding the provisions of Section 31A-22-618.5, a health benefit plan offered in the individual market, the small group market, or the large group market shall:

(a) provide coverage for:

(i) telemedicine services that are covered by Medicare; and

(ii) treatment of a mental health condition through telemedicine services if:

(A) the health benefit plan provides coverage for the treatment of the mental health condition through in-person services; and

(B) the health benefit plan determines treatment of the mental health condition through telemedicine services meets the appropriate standard of care; and

(b) reimburse a network provider that provides the telemedicine services described in Subsection (2)(a) at a negotiated commercially reasonable rate.

(3)(a) Notwithstanding Section 31A-45-303, a health benefit plan providing coverage under Subsection (2) (a) may not impose originating site restrictions, geographic restrictions, or distance-based restrictions.

(b) A network provider that provides the telemedicine services described in Subsection (2)(a) may utilize any synchronous audiovisual technology for the telemedicine services that is compliant with the

federal Health Insurance Portability and Accountability Act of 1996.

## Utah Code § 31A-22-649

*Coverage of telepsychiatric consultations*

(1) As used in this section:

(a) “Telehealth services” means the same as that term is defined in Section 26B-4-704.

(b) “Telepsychiatric consultation” means a consultation between a physician and a board certified psychiatrist, both of whom are licensed to engage in the practice of medicine in the state, that utilizes:

(i) the health records of the patient, provided from the patient or the referring physician;

(ii) a written, evidence-based patient questionnaire; and

(iii) telehealth services that meet industry security and privacy standards, including compliance with the:

(A) Health Insurance Portability and Accountability Act; and

(B) Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 226, 467, as amended.

(2) Beginning January 1, 2019, a health benefit plan that offers coverage for mental health services shall:

(a) provide coverage for a telepsychiatric consultation during or after an initial visit between the patient and a referring in-network physician;

(b) provide coverage for a telepsychiatric consultation from an out-of-network board certified psychiatrist if a telepsychiatric consultation is not made available to a physician within seven business days after the initial request is made by the physician to an in-network provider of telepsychiatric consultations; and

(c) reimburse for the services described in Subsections (2)(a) and (b) at the equivalent in-network or out-of-network rate set by the health

benefit plan after taking into account cost-sharing that may be required under the health benefit plan.

(3) A single telepsychiatric consultation includes all contacts, services, discussion, and information review required to complete an individual request from a referring physician for a patient.

(4) An insurer may satisfy the requirement to cover a telepsychiatric consultation described in Subsection (2)(a) for a patient by:

(a) providing coverage for behavioral health treatment, as defined in Section 31A-22-642, in person or using telehealth services; and

(b) ensuring that the patient receives an appointment for the behavioral health treatment in person or using telehealth services on a date that is within seven business days after the initial request is made by the in-network referring physician.

(5) A referring physician who uses a telepsychiatric consultation for a patient shall, at the time that the questionnaire described in Subsection (1)(b)(ii) is completed, notify the patient that:

(a) the referring physician plans to request a telepsychiatric consultation; and

(b) additional charges to the patient may apply.

(6)(a) An insurer may receive a temporary waiver from the department from the requirements in this section if the insurer demonstrates to the department that the insurer is unable to provide the benefits described in this section due to logistical reasons.

(b) An insurer that receives a waiver from the department under Subsection (6)(a) is subject to the requirements of this section beginning July 1, 2019.

(7) This section does not limit an insurer from engaging in activities that ensure payment integrity or facilitate review and investigation of improper practices by health care providers.

#### **Utah Code § 26B-4-704**

*Scope of telehealth practice—Enforcement (1) As used in this section:*

(a) “Asynchronous store and forward transfer” means the transmission of a patient’s health care information from an originating site to a provider at a distant site.

(b) “Distant site” means the physical location of a provider delivering telemedicine services.

(c) “Originating site” means the physical location of a patient receiving telemedicine services.

(d) “Patient” means an individual seeking telemedicine services.

(e)(i) “Patient-generated medical history” means medical data about a patient that the patient creates, records, or gathers.

(ii) “Patient-generated medical history” does not include a patient’s medical record that a healthcare professional creates and the patient personally delivers to a different healthcare professional.

(f) “Provider” means an individual who is:

(i) licensed under Chapter 2, Part 2, Health Care Facility Licensing and Inspection;

(ii) licensed under Title 58, Occupations and Professions, to provide health care; or

(iii) licensed under Chapter 2, Part 1, Human Services Programs and Facilities.

(g) “Synchronous interaction” means real-time communication through interactive technology that enables a provider at a distant site and a patient at an originating site to interact simultaneously through two-way audio and video transmission.

(h) “Telehealth services” means the transmission of health-related services or information through the use of electronic communication or information technology.

(i) “Telemedicine services” means telehealth services:

(i) including:

(A) clinical care;

(B) health education;

(C) health administration;

(D) home health;

(E) facilitation of self-managed care and caregiver support; or

(F) remote patient monitoring occurring incidentally to general supervision; and

(ii) provided by a provider to a patient through a method of communication that:

(A) uses asynchronous store and forward transfer or synchronous interaction; and



(B) 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.

(2) A provider offering telehealth services shall:

(a) At all times:

(i) Act within the scope of the provider's license under Title 58, Occupations and Professions, in accordance with the provisions of this section and all other applicable laws and rules; and

(ii) Be held to the same standards of practice as those applicable in traditional health care settings;

(b) If the provider does not already have a provider-patient relationship with the patient, establish a provider-patient relationship during the patient encounter in a manner consistent with the standards of practice, determined by the Division of Professional Licensing in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, including providing the provider's licensure and credentials to the patient;

(c) Before providing treatment or prescribing a prescription drug, establish a diagnosis and identify underlying conditions and contraindications to a recommended treatment after:

(i) obtaining from the patient or another provider the patient's relevant clinical history; and

(ii) documenting the patient's relevant clinical history and current symptoms;

(d) be available to a patient who receives telehealth services from the provider for subsequent care related to the initial telemedicine services, in accordance with community standards of practice;

(e) be familiar with available medical resources, including emergency resources near the originating site, in order to make appropriate patient referrals when medically indicated;

(f) in accordance with any applicable state and federal laws, rules, and regulations, generate, maintain, and make available to each patient receiving telehealth services the patient's medical records; and

(g) if the patient has a designated health care provider who is not the telemedicine provider:

(i) consult with the patient regarding whether to provide the patient's designated health care provider a medical record or other report containing an explanation of the treatment provided to the patient and the telemedicine provider's evaluation, analysis, or diagnosis of the patient's condition;

(ii) collect from the patient the contact information of the patient's designated health care provider; and

(iii) within two weeks after the day on which the telemedicine provider provides services to the patient, and to the extent allowed under HIPAA as that term is defined in Section 26B-3-126, provide the medical record or report to the patient's designated health care provider, unless the patient indicates that the patient does not want the telemedicine provider to send the medical record or report to the patient's designated health care provider.

(3) Subsection (2)(g) does not apply to prescriptions for eyeglasses or contacts.

(4) A provider offering telemedicine services may not diagnose a patient, provide treatment, or prescribe a prescription drug based solely on one of the following:

(a) an online questionnaire;

(b) an email message; or

(c) a patient-generated medical history.

(5) A provider may not offer telehealth services if:

(a) the provider is not in compliance with applicable laws, rules, and regulations regarding the provider's licensed practice; or

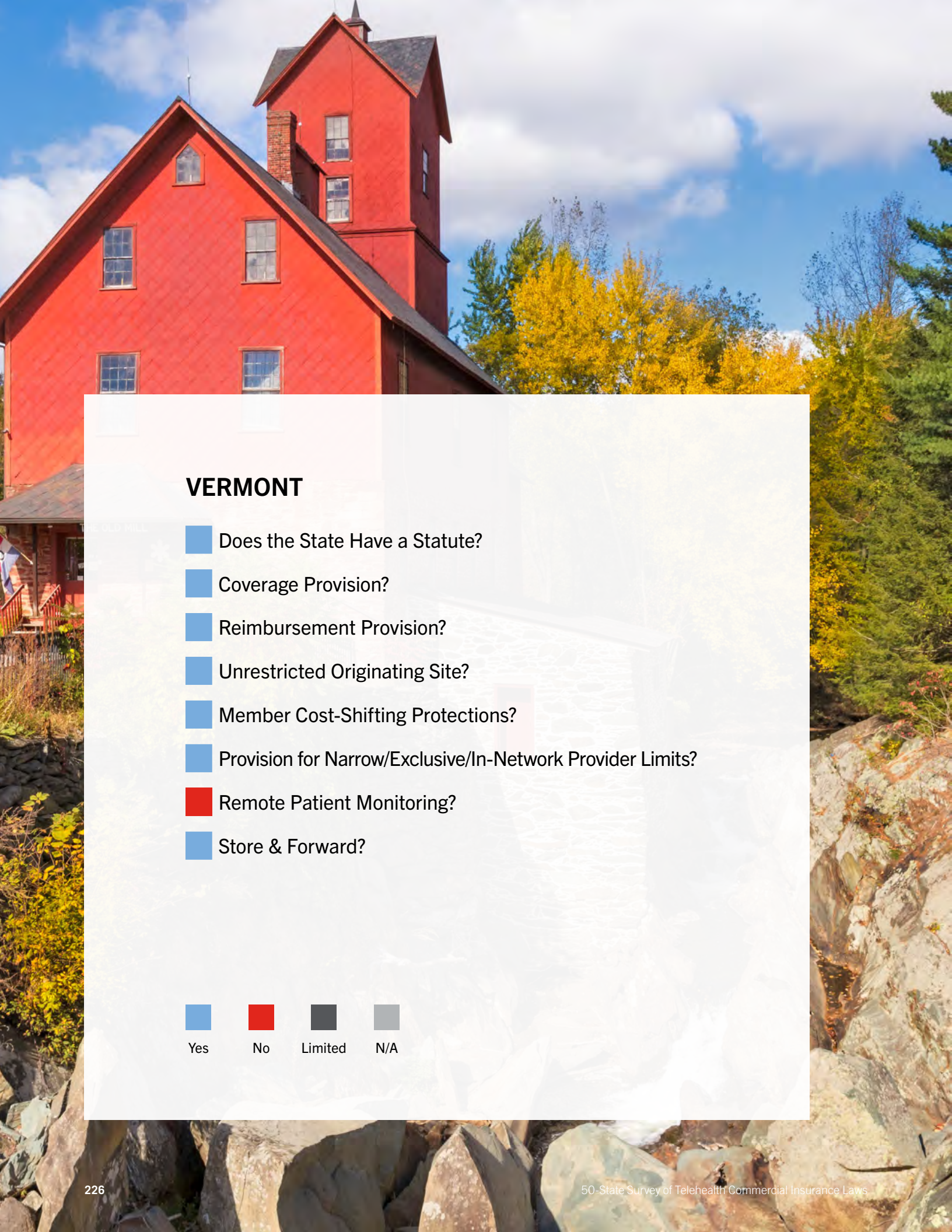
(b) the provider's license under Title 58, Occupations and Professions, is not active and in good standing.

(6)(a) The Division of Professional Licensing created in Section 58-1-103 is authorized to enforce the provisions of this section as it relates to providers licensed under Title 58, Occupations and Professions.

(b) The department is authorized to enforce the provisions of:

(i) this section as it relates to providers licensed under this title; and

(ii) this section as it relates to providers licensed under Chapter 2, Part 1, Human Services Programs and Facilities.



## VERMONT

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes   
  No   
  Limited   
  N/A

# Vermont



**Authority: 8 Vt. Stat. §§ 4100k, 41001**

## **8 Vt. Stat. § 4100k**

*Coverage of telemedicine services and by store-and-forward means*

(a)(1) All health insurance plans in this State shall provide coverage for health care services and dental services 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.

(2) (A) A health insurance plan shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through an in-person visit with the health care provider or through telemedicine.

(B) The provisions of subdivision (A) of this subdivision (2) shall not apply:

(i) To services provided pursuant to the health insurance plan's contract with a third-party telemedicine vendor to provide health care or dental services; or

(ii) In the event that a health insurer and health care provider enter into a value-based contract for health care services that include care delivered through telemedicine or by store-and-forward means.<sup>7</sup>

(b) A health insurance plan may charge a deductible, co-payment, or coinsurance for a health care service or dental service provided through telemedicine as long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(c) A health insurance plan may limit coverage to health care providers in the plan's network. A health insurance plan shall not impose limitations on the number of telemedicine consultations a covered person may receive that exceed limitations otherwise placed on in-person covered services.

(d) Nothing in this section shall be construed to prohibit a health insurance plan from providing coverage for only those services that are medically necessary and are clinically appropriate for delivery through telemedicine, subject to the terms and conditions of the covered person's policy.

(e)(1) A health insurance plan shall reimburse for health care services and dental services delivered by store and forward means.

(2) A health insurance plan shall not impose more than one cost-sharing requirement on a patient for receipt of health care services or dental services delivered by store-and-forward means. If the services would require cost-sharing under the terms of the patient's health insurance plan, the plan may impose the cost-sharing requirement on the services of the originating site health care provider or of the distant site health care provider, but not both.

(f) A health insurer shall not construe a patient's receipt of services delivered through telemedicine or by store-and-forward means as limiting in any way the patient's ability to receive additional covered in-person services from the same or a different health care provider for diagnosis or treatment of the same condition.

(g) Nothing in this section shall be construed to require a health insurance plan to reimburse the distant site health care provider if the distant site health care provider has insufficient information to render an opinion.

(h) In order to facilitate the use of telemedicine in treating substance use disorder, when the originating site is a health care facility, health insurers and the Department of Vermont Health Access shall ensure that the health care provider at the distant site and the health care facility at the originating site are both reimbursed for the services rendered, unless the health care providers at both the distant and originating sites are employed by the same entity.

<sup>7</sup>Text of subdiv. (a)(2) is repealed effective January 1, 2026, pursuant to 2019, Adj. Sess., No. 91, § 27.



(i) As used in this subchapter:

(1) “Distant site” means the location of the health care provider delivering services through telemedicine at the time the services are provided.

(2) “Health insurance plan” means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402; a stand-alone dental plan or policy or other dental insurance plan offered by a dental insurer; and Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State. The term does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

(3) “Health care facility” shall have the same meaning as in 18 V.S.A. § 9402.

(4) “Health care provider” means a person, partnership, or corporation, other than a facility or institution, that is licensed, certified, or otherwise authorized by law to provide professional health care services, including dental services, in this State to an individual during that individual’s medical care, treatment, or confinement.

(5) “Originating site” means 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 the patient’s workplace.

(6) “Store and forward” means an asynchronous transmission of medical information, such as one or more video clips, audio clips, still images, x-rays, magnetic resonance imaging scans, electrocardiograms, electroencephalograms, or laboratory results, sent over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 to be reviewed at a later date by a health care provider at a distant site who is trained in the relevant specialty. In store and forward, the health care provider at the distant site reviews the medical information without the patient present in real time and communicates a care plan or treatment recommendation back to the patient or referring provider, or both.

(7) “Telemedicine” means the delivery of health care services, including dental services, such as diagnosis, consultation, or treatment 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, Pub. L. No. 104-191.

#### **Vt. Stat. Ann. tit. 8, § 4100I**

##### *Coverage of health care services delivered by audio-only telephone*

(a) As used in this section:

(1) “Health care provider” means a person, partnership, or corporation, other than a facility or institution, that is licensed, certified, or otherwise authorized by law to provide professional health care services in this State to an individual during that individual’s medical care, treatment, or confinement.

(2) “Health insurance plan” means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402; Medicaid, to the extent permitted by the Centers for Medicare and Medicaid Services; and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State. The term does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

(b)(1) A health insurance plan shall provide coverage for all medically necessary, clinically appropriate health care services delivered remotely by audio-only telephone to the same extent that the plan would cover the services if they were provided through in-person consultation. Services covered under this subdivision shall include services that are covered when provided in the home by home health agencies.

(2) A health insurance plan may charge an otherwise permissible deductible, co-payment, or coinsurance for a health care service delivered by audio-only telephone, provided that it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(3) A health insurance plan shall not require a health care provider to have an existing relationship with a patient in order to be reimbursed for health care services delivered by audio-only telephone.

## VIRGINIA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A

# Virginia



**Authority: Va. Code § 38.2-3418.16**

## **Va. Code § 38.2-3418.16**

(expansion eff. Jan. 1, 2021)

### *Coverage for telemedicine services*

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

B. As used in this section:

“Originating site” means the location where the patient is located at the time services are provided by a health care provider through telemedicine services.

“Remote patient monitoring services” means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

“Telemedicine services” as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient’s diagnosis or treatment, regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided. “Telemedicine services” does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire. “Telemedicine services” does not include an audio-only telephone, electronic mail

message, facsimile transmission, or online questionnaire. Nothing in this section shall preclude coverage for a service that is not a telemedicine service, including services delivered through real-time audio-only telephone.

C. An insurer, corporation or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

D. An insurer, corporation or health maintenance organization shall not be required to reimburse the treating provider or the consulting provider for technical fees or costs for the provision of telemedicine services; however, such insurer, corporation or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation or health maintenance organization is responsible for coverage for the provision of the same service through face-to-face consultation or contact. No insurer, corporation, or health maintenance organization shall require a provider to use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

E. Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require pre-authorization of emergent telemedicine services.

F. An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement





for a health care service provided through telemedicine services, provided that the deductible, copayment or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through face-to-face diagnosis, consultation, or treatment.

G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

H. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued or extended in the Commonwealth on and after January 1, 2021, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

I. This section shall not apply to short-term travel, accident-only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under federal governmental plans.

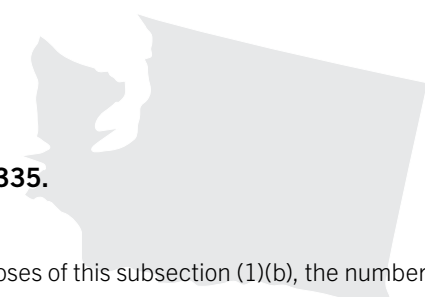
J. The coverage required by this section shall include the use of telemedicine technologies as it pertains to medically necessary remote patient monitoring services to the full extent that these services are available.

## WASHINGTON

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Washington



**Authorities:** Wash. Rev. Code §§ 48.43.735, 41.05.700, 71.24.335.

## Wash. Rev. Code § 48.43.735

*Insurance Reform—Reimbursement of health care services provided through telemedicine or store and forward technology -Audio-only telemedicine*

(1)(a) For health plans issued or renewed on or after January 1, 2017, a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine or store and forward technology if:

- (i) The plan provides coverage of the health care service when provided in person by the provider;
- (ii) The health care service is medically necessary;
- (iii) 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 in effect on January 1, 2015;
- (iv) 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; and
- (v) Beginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider.

(b)(i) Except as provided in (b)(ii) of this subsection, for health plans issued or renewed on or after January 1, 2021, a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine the same amount of compensation the carrier would pay the provider if the health care service was provided in person by the provider.

(ii) Hospitals, hospital systems, telemedicine companies, and provider groups consisting of eleven or more providers may elect to negotiate an amount of compensation for telemedicine services that differs from the amount of compensation for in-person services.

(iii) For purposes of this subsection (1)(b), the number of providers in a provider group refers to all providers within the group, regardless of a provider's location.

(2) For purposes of this section, reimbursement of store and forward technology is available only for those covered services specified in the negotiated agreement between the health carrier and the health care provider.

(3) An originating site for a telemedicine health care service subject to subsection (1) of this section includes a:

- (a) Hospital;
- (b) Rural health clinic;
- (c) Federally qualified health center;
- (d) Physician's or other health care provider's office;
- (e) Licensed or certified behavioral health agency;
- (f) Skilled nursing facility;
- (g) Home or any location determined by the individual receiving the service; or
- (h) Renal dialysis center, except an independent renal dialysis center.

(4) Except for subsection (3)(g) of this section, any originating site under subsection (3) of this section may charge a facility fee for infrastructure and preparation of the patient. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the health carrier. A distant site, a hospital that is an originating site for audio-only telemedicine, or any other site not identified in subsection (3) of this section may not charge a facility fee.

(5) A health carrier may not distinguish between originating sites that are rural and urban in providing the coverage required in subsection (1) of this section.

(6) A health carrier may subject coverage of a telemedicine or store and forward technology health service under subsection (1) of this section to all terms and conditions of the plan in which the covered person is enrolled including, but not limited to,

utilization review, prior authorization, deductible, copayment or coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.

(7) This section does not require a health carrier to reimburse:

- (a) An originating site for professional fees;
- (b) A provider for a health care service that is not a covered benefit under the plan; or
- (c) An originating site or health care provider when the site or provider is not a contracted provider under the plan.

(8)(a) If a provider intends to bill a patient or the patient's health plan for an audio-only telemedicine service, the provider must obtain patient consent for the billing in advance of the service being delivered.

(b) If the commissioner has cause to believe that a provider has engaged in a pattern of unresolved violations of this subsection (8), the commissioner may submit information to the appropriate disciplining authority, as defined in RCW 18.130.020, for action. Prior to submitting information to the appropriate disciplining authority, the commissioner may provide the provider with an opportunity to cure the alleged violations or explain why the actions in question did not violate this subsection (8).

(c) If the provider has engaged in a pattern of unresolved violations of this subsection (8), the appropriate disciplining authority may levy a fine or cost recovery upon the provider in an amount not to exceed the applicable statutory amount per violation and take other action as permitted under the authority of the disciplining authority. Upon completion of its review of any potential violation submitted by the commissioner or initiated directly by an enrollee, the disciplining authority shall notify the commissioner of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation.

(9) For purposes of this section:

(a)(i) "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

(ii) For purposes of this section only, "audio-only telemedicine" does not include:

- (A) The use of facsimile or email; or
  - (B) The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results;
- (b) "Disciplining authority" has the same meaning as in RCW 18.130.020;
- (c) "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine;

(d) "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and:

(i) For health care services included in the essential health benefits category of mental health and substance use disorder services, including behavioral health treatment:

(A) The covered person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(B) The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine;

(ii) For any other health care service:

(A) The covered person has had, within the past two years, at least one in-person appointment, or, until July 1, 2024, at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the

same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(B) The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past two years, at least one in-person appointment, or, until July 1, 2024, at least one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine;

(e) “Health care service” has the same meaning as in RCW 48.43.005;

(f) “Hospital” means a facility licensed under chapter 70.41, 71.12, or 72.23 RCW;

(g) “Originating site” means the physical location of a patient receiving health care services through telemedicine;

(h) “Provider” has the same meaning as in RCW 48.43.005;

(i) “Store and forward technology” means use of an asynchronous transmission of a covered person’s medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile or email; and

(j) “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” includes audio-only telemedicine, but does not include facsimile, or email.

(10) The commissioner may adopt any rules necessary to implement this section.

### **Wash. Rev. Code § 41.05.700**

*State Health Care Authority—Reimbursement of health care services provided through telemedicine or store and forward technology -Audio-only telemedicine*

(1)(a) A health plan offered to employees, school employees, and their covered dependents under this chapter issued or renewed on or after January 1, 2017, shall reimburse a provider for a health care service provided to a covered person through telemedicine or store and forward technology if:

(i) The plan provides coverage of the health care service when provided in person by the provider;

(ii) The health care service is medically necessary;

(iii) 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 in effect on January 1, 2015;

(iv) 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; and

(v) Beginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider.

(b)(i) Except as provided in (b)(ii) of this subsection, a health plan offered to employees, school employees, and their covered dependents under this chapter issued or renewed on or after January 1, 2021, shall reimburse a provider for a health care service provided to a covered person through telemedicine the same amount of compensation the carrier would pay the provider if the health care service was provided in person by the provider.

(ii) Hospitals, hospital systems, telemedicine companies, and provider groups consisting of eleven or more providers may elect to an amount of compensation for telemedicine services that differs from the amount of compensation for in-person services.

(iii) For purposes of this subsection (1)(b), the number of providers in a provider group refers to all providers within the group, regardless of a provider’s location.

(2) For purposes of this section, reimbursement of store and forward technology is available only for those covered services specified in the negotiated agreement between the health plan and health care provider.

(3) An originating site for a telemedicine health care service subject to subsection (1) of this section includes a:

(a) Hospital;

(b) Rural health clinic;

(c) Federally qualified health center;

- (d) Physician's or other health care provider's office;
- (e) Licensed or certified behavioral health agency;
- (f) Skilled nursing facility;
- (g) Home or any location determined by the individual receiving the service; or
- (h) Renal dialysis center, except an independent renal dialysis center.

(4) Except for subsection (3)(g) of this section, any originating site under subsection (3) of this section may charge a facility fee for infrastructure and preparation of the patient. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the health plan. A distant site, a hospital that is an originating site for audio-only telemedicine, or any other site not identified in subsection (3) of this section may not charge a facility fee.

(5) The plan may not distinguish between originating sites that are rural and urban in providing the coverage required in subsection (1) of this section.

(6) The plan may subject coverage of a telemedicine or store and forward technology health service under subsection (1) of this section to all terms and conditions of the plan including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.

(7) This section does not require the plan to reimburse:

- (a) An originating site for professional fees;
- (b) A provider for a health care service that is not a covered benefit under the plan; or
- (c) An originating site or health care provider when the site or provider is not a contracted provider under the plan.

(8)(a) If a provider intends to bill a patient or the patient's health plan for an audio-only telemedicine service, the provider must obtain patient consent for the billing in advance of the service being delivered.

(b) If the health care authority has cause to believe that a provider has engaged in a pattern of unresolved violations of this subsection (8), the health care authority may submit information to the appropriate disciplining authority, as defined in RCW 18.130.020, for action. Prior to submitting information to the appropriate disciplining authority, the health care

authority may provide the provider with an opportunity to cure the alleged violations or explain why the actions in question did not violate this subsection (8).

(c) If the provider has engaged in a pattern of unresolved violations of this subsection (8), the appropriate disciplining authority may levy a fine or cost recovery upon the provider in an amount not to exceed the applicable statutory amount per violation and take other action as permitted under the authority of the disciplining authority. Upon completion of its review of any potential violation submitted by the health care authority or initiated directly by an enrollee, the disciplining authority shall notify the health care authority of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation.

(9) For purposes of this section:

(a)(i) "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

(ii) For purposes of this section only, "audio-only telemedicine" does not include:

(A) The use of facsimile or email; or

(B) The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results;

(b) "Disciplining authority" has the same meaning as in RCW 18.130.020;

(c) "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine;

(d) "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and:

(i) For health care services included in the essential health benefits category of mental health and substance use disorder services, including behavioral health treatment:

(A) The covered person has had, within the past three years, at least one in-person appointment, or at least

one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(B) The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine;

(ii) For any other health care service:

(A) The covered person has had, within the past two years, at least one in-person appointment, or, until July 1, 2024, at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(B) The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past two years, at least one in-person appointment, or, until July 1, 2024, at least one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine;

(e) “Health care service” has the same meaning as in RCW 48.43.005;

(f) “Hospital” means a facility licensed under chapter 70.41, 71.12, or 72.23 RCW;

(g) “Originating site” means the physical location of a patient receiving health care services through telemedicine;

(h) “Provider” has the same meaning as in RCW 48.43.005;

(i) “Store and forward technology” means use of an asynchronous transmission of a covered person’s medical information from an originating site to the health care provider at a distant site which results in

medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email; and

(j) “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” includes audio-only telemedicine, but does not include facsimile, or email.

### **Wash. Rev. Code § 71.24.335**

*Community Behavioral Health Services Act—Reimbursement for behavioral health services provided through telemedicine or store and forward technology—Coverage requirements -Audio-only telemedicine*

(1) Upon initiation or renewal of a contract with the authority, behavioral health administrative services organizations and managed care organizations shall reimburse a provider for a behavioral health service provided to a covered person through telemedicine or store and forward technology if:

(a) The behavioral health administrative services organization or managed care organization in which the covered person is enrolled provides coverage of the behavioral health service when provided in person by the provider;

(b) The behavioral health service is medically necessary; and

(c) Beginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider.

(2)(a) If the service is provided through store and forward technology there must be an associated visit between the covered person and the referring provider. Nothing in this section prohibits the use of telemedicine for the associated office visit.

(b) For purposes of this section, reimbursement of store and forward technology is available only for those services specified in the negotiated agreement between the behavioral health administrative services organization, or managed care organization, and the provider.

(3) An originating site for a telemedicine behavioral health service subject to subsection (1) of this section means an originating site as defined in rule by the department or the health care authority.

(4) Any originating site, other than a home, under subsection (3) of this section may charge a facility fee for infrastructure and preparation of the patient. Reimbursement must be subject to a negotiated agreement between the originating site and the behavioral health administrative services organization, or managed care organization, as applicable. A distant site, a hospital that is an originating site for audio-only telemedicine, or any other site not identified in subsection (3) of this section may not charge a facility fee.

(5) Behavioral health administrative services organizations and managed care organizations may not distinguish between originating sites that are rural and urban in providing the coverage required in subsection (1) of this section.

(6) Behavioral health administrative services organizations and managed care organizations may subject coverage of a telemedicine or store and forward technology behavioral health service under subsection (1) of this section to all terms and conditions of the behavioral health administrative services organization or managed care organization in which the covered person is enrolled, including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable behavioral health care service provided in person.

(7) This section does not require a behavioral health administrative services organization or a managed care organization to reimburse:

- (a) An originating site for professional fees;
- (b) A provider for a behavioral health service that is not a covered benefit; or
- (c) An originating site or provider when the site or provider is not a contracted provider.

(8)(a) If a provider intends to bill a patient, a behavioral health administrative services organization, or a managed care organization for an audio-only telemedicine service, the provider must obtain patient consent for the billing in advance of the service being delivered.

(b) If the health care authority has cause to believe that a provider has engaged in a pattern of unresolved violations of this subsection (8), the health care authority may submit information to the appropriate disciplining authority, as defined in RCW 18.130.020,

for action. Prior to submitting information to the appropriate disciplining authority, the health care authority may provide the provider with an opportunity to cure the alleged violations or explain why the actions in question did not violate this subsection (8).

(c) If the provider has engaged in a pattern of unresolved violations of this subsection (8), the appropriate disciplining authority may levy a fine or cost recovery upon the provider in an amount not to exceed the applicable statutory amount per violation and take other action as permitted under the authority of the disciplining authority. Upon completion of its review of any potential violation submitted by the health care authority or initiated directly by an enrollee, the disciplining authority shall notify the health care authority of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation.

(9) For purposes of this section:

(a)(i) "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

(ii) For purposes of this section only, "audio-only telemedicine" does not include:

(A) The use of facsimile or email; or

(B) The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results;

(b) "Disciplining authority" has the same meaning as in RCW 18.130.020;

(c) "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine;

(d) "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and:

(i) The covered person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both



audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(ii) The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine;

(e) "Hospital" means a facility licensed under chapter 70.41, 71.12, or 72.23 RCW;

(f) "Originating site" means the physical location of a patient receiving behavioral health services through telemedicine;

(g) "Provider" has the same meaning as in RCW 48.43.005;

(h) "Store and forward technology" means use of an asynchronous transmission of a covered person's medical or behavioral health information from an originating site to the provider at a distant site which results in medical or behavioral health diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email; and

(i) "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.

(10) The authority must adopt rules as necessary to implement the provisions of this section.

## WEST VIRGINIA

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A

# West Virginia

**Authorities: W. Va. Code §§ 33-57-1, 5-16-7b**

## **W. Va. Code § 33-57-1**

*Insurance—Coverage of telehealth services*

(a) The following terms are defined:

(1) “Distant site” means the telehealth site where the health care practitioner is seeing the patient at a distance or consulting with a patient’s health care practitioner.

(2) “Established patient” means a patient who has received professional services, face-to-face, from the physician, qualified health care professional, or another physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

(3) “Health care practitioner” means a person licensed under § 30-1-1 et seq. of this code who provides health care services.

(4) “Originating site” means the location where the patient is located, whether or not accompanied by a health care practitioner, at the time services are provided by a health care practitioner through telehealth, including, but not limited to, a health care practitioner’s office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient’s home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

(5) “Remote patient monitoring services” means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

(6) “Telehealth services” means the use of synchronous or asynchronous telecommunications technology or audio only telephone calls by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of

medical data; patient and professional health-related education; public health services; and health administration. The term does not e-mail messages, or facsimile transmissions.

(7) “Virtual telehealth” means a new patient or follow-up patient for acute care that does not require chronic management or scheduled medications.

(b) Notwithstanding the provisions of § 33-1-1 et seq. of this code, an insurer subject to § 33-15-1 et seq., § 33-16-1 et seq., § 33-24-1 et seq., § 33-25-1 et seq., and § 33-25A-1 et seq. of this code which issues or renews a health insurance policy on or after July 1, 2020, shall provide coverage of health care services provided through telehealth services if those same services are covered through face-to-face consultation by the policy.

(c) An insurer subject to § 33-15-1 et seq., § 33-16-1 et seq., § 33-24-1 et seq., § 33-25-1 et seq., and § 33-25A-1 et seq. of this code which issues or renews a health insurance policy on or after July 1, 2020, may not exclude a service for coverage solely because the service is provided through telehealth services.

(d) An insurer subject to § 33-15-1 et seq., § 33-16-1 et seq., § 33-24-1 et seq., § 33-25-1 et seq., and § 33-25A-1 et seq. of this code which issues, renews, amends, or adjusts a plan, policy, contract, or agreement on or after July 1, 2021, shall provide reimbursement for a telehealth service at a rate negotiated between the provider and the insurance company for the virtual telehealth encounter.

An insurer subject to § 33-15-1 et seq., § 33-16-1 et seq., § 33-24-1 et seq., § 33-25-1 et seq., and § 33-25A-1 et seq. of this code which issues, renews, amends, or adjusts a plan, policy, contract, or agreement on or after July 1, 2021, shall provide reimbursement for a telehealth service for an established patient, or care rendered on a consulting basis to a patient located in an acute care facility whether inpatient or outpatient on the same basis and at the same rate under a contract, plan, agreement, or policy as if the service is provided through an in-person encounter rather than provided via telehealth.



(e) An insurer subject to § 33-15-1 et seq., § 33-16-1 et seq., § 33-24-1 et seq., § 33-25-1 et seq., and § 33-25A-1 et seq. of this code may not impose any annual or lifetime dollar maximum on coverage for telehealth services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to the provisions of or the requirements of this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(f) An originating site may charge an insurer subject to § 33-15-1 et seq., § 33-16-1 et seq., § 33-24-1 et seq., § 33-25-1 et seq., and § 33-25A-1 et seq. of this code a site fee.

(g) The coverage required by this section shall include the use of telehealth technologies as it pertains to medically necessary remote patient monitoring services to the full extent that those services are available.

#### **W. Va. Code § 5-16-7b**

##### *West Virginia Public Employees Insurance Act—Coverage for telehealth services*

(a) The plan shall provide coverage of health care services provided through telehealth services if those same services are covered through face-to-face consultation by the policy.

(b) The plan may not exclude a service for coverage solely because the service is provided through telehealth services.

(c) The plan shall provide reimbursement for a telehealth service at a rate negotiated between the provider and the insurance company for virtual telehealth encounters. The plan shall provide reimbursement for a telehealth service for an established patient, or care rendered on a consulting basis to a patient located in an acute care facility, whether inpatient or outpatient, on the same basis and at the same rate under a contract, plan, agreement, or policy as if the service is provided through an in-person encounter rather than provided via telehealth.

(d) The plan may not impose any annual or lifetime dollar maximum on coverage for telehealth services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to the provisions of or the requirements of this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(4) An originating site may charge the plan a site fee.

(f) The coverage required by this section shall include the use of telehealth technologies as it pertains to medically necessary remote patient monitoring services to the full extent that those services are available.



# WISCONSIN

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?

Yes     No     Limited     N/A

# Wisconsin

There are currently no commercial payer telehealth statutes in this state.



## WYOMING

- Does the State Have a Statute?
- Coverage Provision?
- Reimbursement Provision?
- Unrestricted Originating Site?
- Member Cost-Shifting Protections?
- Provision for Narrow/Exclusive/In-Network Provider Limits?
- Remote Patient Monitoring?
- Store & Forward?



Yes



No



Limited



N/A



# Wyoming

There are currently no commercial payer telehealth statutes in this state.





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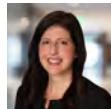
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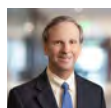
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