



50-State Survey of Telehealth Commercial Insurance Laws

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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. 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.

The year 2020 introduced a massive array of new changes to state telehealth laws and rules in connection with the COVID-19 public health emergency. Many of those changes are on a temporary basis, and states typically have kept their COVID-19 telehealth emergency rules separate from their permanent telehealth coverage policies. Such temporary coverage policies are not included in this 2021 report. If a state has introduced a legal change during COVID-19 and made that change permanent, we have incorporated those laws into this report. Every effort was made to capture the most recent policy language in each state as of January 2021.

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Executive Summary

Telemedicine and digital health technology continues to gain acceptance among patients and health care professionals alike, and more organizations are implementing and expanding robust virtual care programs to supplement their traditional in-person offerings. Our first national telemedicine and digital health survey was published seven years ago, with this report being our team's fourth publicly available survey on telemedicine. Our prior reports found one of the most significant barriers to adoption was limited or unclear reimbursement for telehealth and digital health services.

Enter the COVID-19 pandemic, which compelled state and federal policymakers to remove restrictions and expand reimbursement for telehealth and virtual care at a rate previously unseen. The new changes followed the previously established pathway of coverage, but the pace at which they were made was stunning. Medicare introduced nearly 100 telehealth service codes covered on a temporary basis until the federal public health emergency declaration expires, including payment for telephone-only consults. States and commercial health plans followed suit. Although some of the reimbursement expansions are temporary and slated to end when the public health emergency expires, many have already become permanently codified into state law.

Foley & Lardner's *2021 50-State Survey of Telehealth Commercial Insurance Laws* provides a detailed landscape of the state telehealth commercial insurance coverage and payment laws. 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.

In the time since our 2019 report, the legal landscape for telehealth reimbursement has significantly improved. Currently, 43 states and DC maintain some sort of telehealth commercial payer statute, with West Virginia joining the list in 2020. Yet, the quality and efficacy of these laws varies significantly from state to state. For example, three states have telehealth coverage laws on the books that do not actually mandate health plans to cover services delivered via telehealth (Florida, Illinois, and Michigan).

And while telehealth coverage has widely expanded, the same cannot be said for reimbursement/payment parity. Currently, 22 states maintain laws expressly addressing reimbursement of telehealth services (an increase from 16 states in 2019), and 14 of those offer true "payment parity" (an increase from 10 in 2019), meaning that providers outside those 14 states may find they receive lower payment for telehealth-based services compared to in-person services (i.e., same service

code, but different reimbursement rates). States with payment parity laws are Arkansas, California, Delaware, Georgia, Hawaii, Kentucky, Minnesota, Missouri, New Mexico, Texas, Utah, Vermont, Virginia, and Washington. In addition, the new Massachusetts law offers true payment parity, but only for behavioral health services. Massachusetts also temporarily extended payment parity for: (i) primary care and chronic disease management services via telehealth over the next two years, and (ii) all other health care services, which have been temporarily mandated by a gubernatorial Executive Order, for 90 days beyond the end of the COVID-19 state of emergency.

Other limitations on telehealth commercial insurance reimbursement continue to exist in some states, but the trend is towards equitable treatment for telehealth. For example, only one state (Tennessee) still maintains some restrictions on the patient's originating site. And 30 states have cost shifting protections, which prohibit a plan from charging a patient a deductible, co-insurance, and/or co-payment for a telehealth consultation that exceeds what the insurer would charge for the same service if it were provided during an in-person consultation.

Coverage of asynchronous telehealth and remote patient monitoring also has grown. Patients and providers continue to push for more virtual care services, and health plans are beginning to offer meaningful coverage of these modalities. More than half of the states (27 states) mandate coverage for store-and-forward/asynchronous telehealth. And 17 states require commercial health plans to cover remote patient monitoring services. These laws benefit patients by increasing access and availability to health care services, and catalyze the growth of telehealth technologies throughout the country.

We are pleased to share this 50-state survey of state telehealth commercial payer statutes. This survey contains pinpoint citations to the governing statutes or rules, but includes only commercial health insurance laws and does not include Medicaid fee-for-service rules or Medicaid managed care organization laws and rules, which also vary on a state-by-state basis.

CURRENTLY, 43 STATES AND DC MAINTAIN SOME SORT OF TELEHEALTH COMMERCIAL PAYER STATUTE, WITH WEST VIRGINIA JOINING THE LIST IN 2020

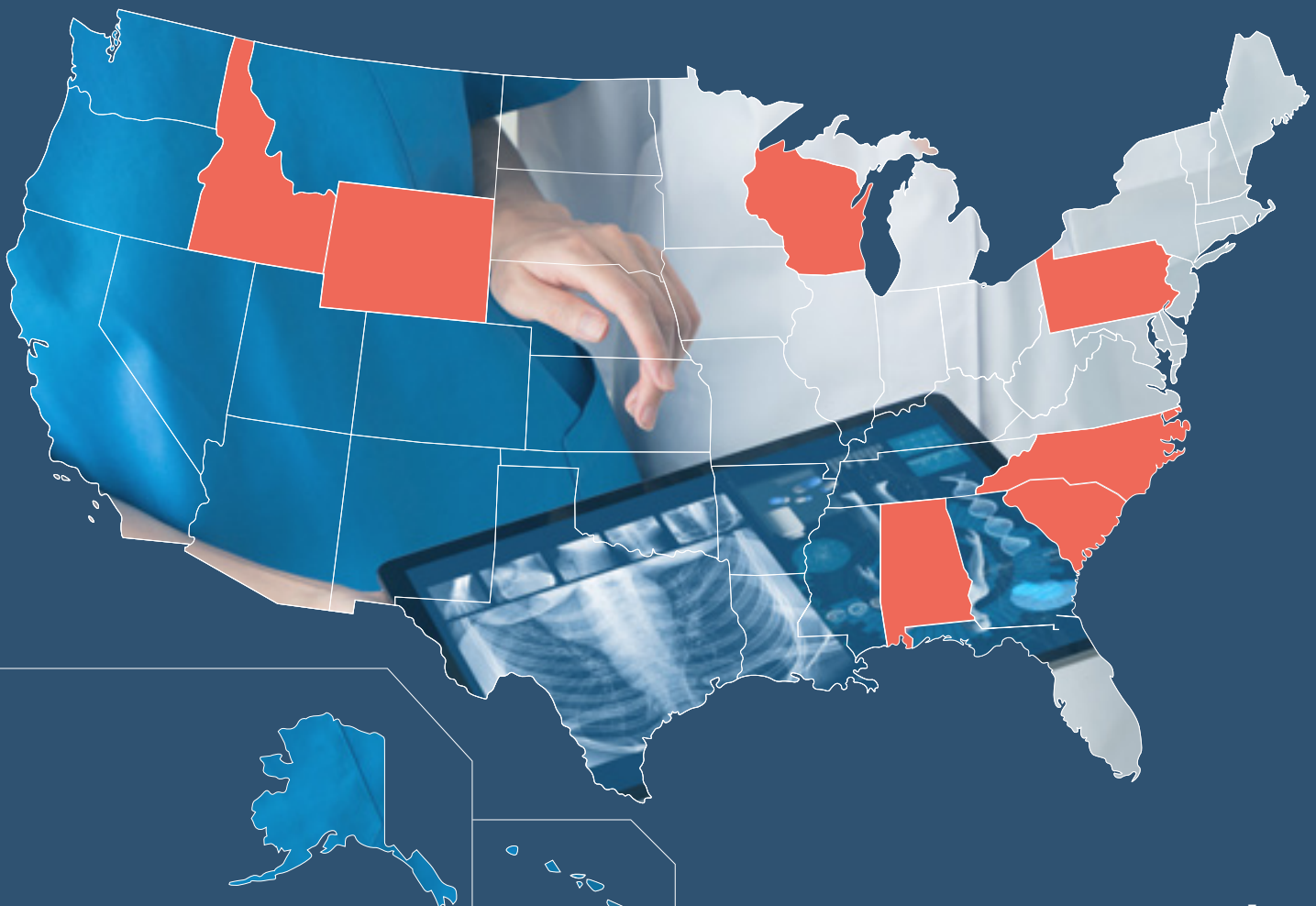
The heat maps that follow provide a summary of the following:

- 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, co-insurance, and/or co-payment for a telehealth consultation that exceeds what the insurer would charge for the same service if it were provided during an in-person consultation?

● States with no commercial payer telehealth statutes



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?

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 checkup 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).

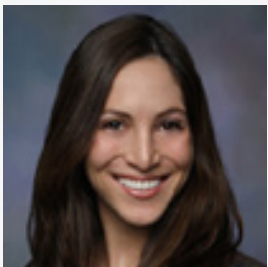
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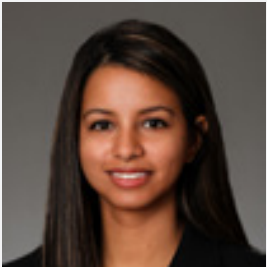
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State Telehealth Commercial Payer Statutes (Last updated Feb. 1, 2021)

The tables below are interpretive summaries only, not legal advice. Laws and rules are constantly changing, so be certain to reference and read the statutes and regulations for precise legal requirements.

 YES
  NO
  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		N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
AK									Alaska Stat. §§ 21.42.422, 47.05.270(e)
AZ									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)
AR									Ark. Code §§ 23-79-1601, 23-79-1602
CA									Cal. Health & Safety Code §§ 1374.13, 1374.14; Cal. Ins. Code §§ 10123.85, 10123.855; Cal. Bus. & Prof. Code § 2290.5
CO									Colo. Rev. Stat. § 10-16-123
CT									Conn. Gen. Stat. §§ 38a-499a, 38a-526, 19a-906
DE									18 Del. Code §§ 3370, 3571R; 18 Del. Admin. Code 1409-2.0, -3.0
DC									D.C. Code §§ 31-3861, 31-3862
FL									Fla. Stat. §§ 627.42396, 641.31(45), 456.47(1)
GA									Ga. Code § 33-24-56.4
HI									Haw. Rev. Stat. §§ 431:10A-116.3; 432D-23.5; 453.1.3(h)
ID		N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
IL		LTD							215 Ill. Comp. Stat. 5/356z.22

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IN	✓	✓	✗	✓	✓	✗	✗	✗	Ind. Code § 27-8-34 et seq., 27-13-7-22
IA	✓	✓	✗	✓	✗	✗	✗	✗	Iowa Code §§ 514C.34, 514C.35
KS	✓	✓	✗	✓	✓	✗	✗	✓	Kan. Stat. §§ 40-2,211; 40-2,213
KY	✓	✓	✓	✓	✓	✓	✗	✓	Ky. Rev. Stat. §§ 304.17A-138, 304.17A-005
LA	✓	✓ (but references orig. site physician only)	✓ (75%)	✓	✗	✗	✗	✗	La. Stat. § 22:1821; La. Stat. § 22:1841-44; 46 La. Admin. Code Pt. XLV, 7503
ME	✓	✓	✗	✓	✓	✓	✓	✓	Me. Rev. Stat. tit. 24-A, § 4316
MD	✓	✓	✗	✓	✗	✓	✗	✗	Md. Code, Ins. § 15-139
MA	✓	✓	✓	✓	✓	✓	✓	✓	M.G.L.A. 175 § 47MM (applying to individual accident and sickness insurance); M.G.L.A. 176A § 38 (applying to nonprofit hospital service corporation plans); M.G.L.A. 176B § 25 (applying to medical service corporations); M.G.L.A. 176G § 33 (applying to health maintenance organizations); M.G.L.A. 176I § 13 (applying to a preferred provider organization contract); M.G.L.A. 32A § 30 (applying to contributory group general or blanket insurance contracts for government employees); M.G.L.A. 176O §§ 1, 6 (health insurance consumer protections); S2984, §§ 68, 69 (not codified; providing payment parity)
MI	✓	LTD	✗	✓	✗	✗	✗	✓	Mich. Comp. Laws §§ 500.3476, 550.1401k
MN	✓	✓	✓	✓	✓	✗	✗	✓	Minn. Stat. § 62A.671-.672
MS	✓	✓	✗	✓	✓	✓	✓	✓	Miss. Code §§ 83-9-351, 83-9-353
MO	✓	✓	✓	✓	✓	✓	✗	✓	Mo. Stat. § 376.1900
MT	✓	✓	✗	✓	✓	✗	✗	✓	Mont. Code § 33-22-138
NE	✓	✓	✗	✓	✓	✗	✓	✓	Neb. Rev. Stat. §§ 44-7,107; 44-312

	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
NV									Nev. Rev. Stat. § 689A.0463 (for individual health insurance policies); Nev. Rev. Stat. § 689B.0369 (for group and blanket health policies); Nev. Rev. Stat. § 689C.195 (for small employer health benefit plans); Nev. Rev. Stat. § 616C.730 (for industrial insurance); Nev. Rev. Stat. § 695A.265 (for fraternal benefit societies); Nev. Rev. Stat. § 695B.1904 (for nonprofit corporations for hospital, medical and dental service contracts); Nev. Rev. Stat. § 695C.1708 (for health maintenance organizations); Nev. Rev. Stat. § 695D.216 (for dental plans); Nev. Rev. Stat. § 695G.162 (for managed care organizations); Nev. Rev. Stat. § 629.515 (providing definitions ascribed by above referenced statutes).
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 (for group health coverage, including any form of self-insurance); N.M. Stat. § 59A-46-50.3 (for individual or group health maintenance organization contracts); N.M. Stat. § 59A-22-49.3 (for individual or group health insurance policy, health care plan or certificate of health insurance); N.M. Stat. § 59A-23-7.12 (for blanket or group health insurance policy); N.M. Stat. § 59A-47-45.3 (for individual or group nonprofit health care plan policies)
NY									N.Y. Ins. Law § 3217-h (applying to life, accident and health insurance contracts); N.Y. Ins. Law § 4306-g (applying to insurance provided under non-profit medical or health and hospital service corporations); N.Y. Pub. Health Law § 4406-g (applying to health maintenance organizations)
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 (expansion eff. Jan. 1, 2021)
OK		LTD							36 Okla. St. §§ 6802, 6803

	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
OR	✓	✓	✗	✓	LTD	✓	✗	✗	Or. Rev. Stat. §§ 743A.058, 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
UT	✓	LTD	✓	✓	✗	✓	LTD	LTD	Utah Code §§ 31A-22-649.5, 31A-22-649, 26-60-102
VT	✓	✓	✓	✓	✓	✓	✗	✓	8 Vt. Stat. § 4100k
VA	✓	✓	✓	✓	✓	✗	✓	✗	Va. Code § 38.2-3418.16
WA	✓	LTD	✓	✓	✓	✓	✗	✓	Wash. Rev. Code §§ 48.43.735 (insurance expansion eff. Jan. 1, 2021), 41.05.700 (state employee health plans), 71.24.335 (behavioral health administrative services organizations and managed care organizations)
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

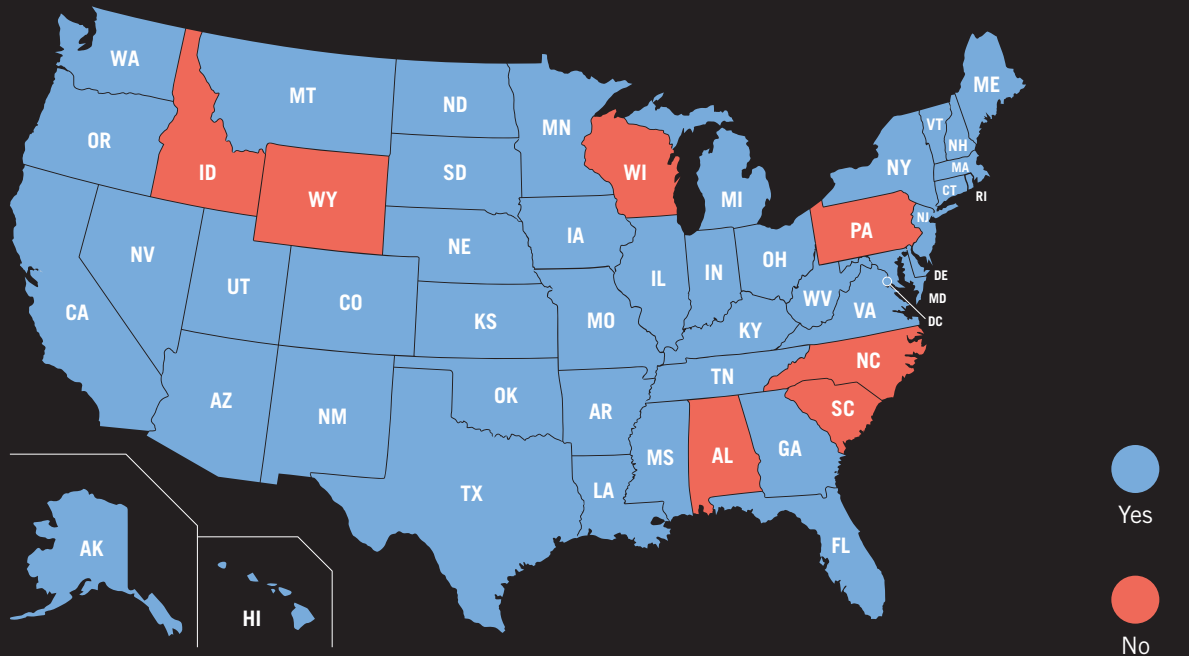


State Telehealth Commercial Payer Statutes

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.

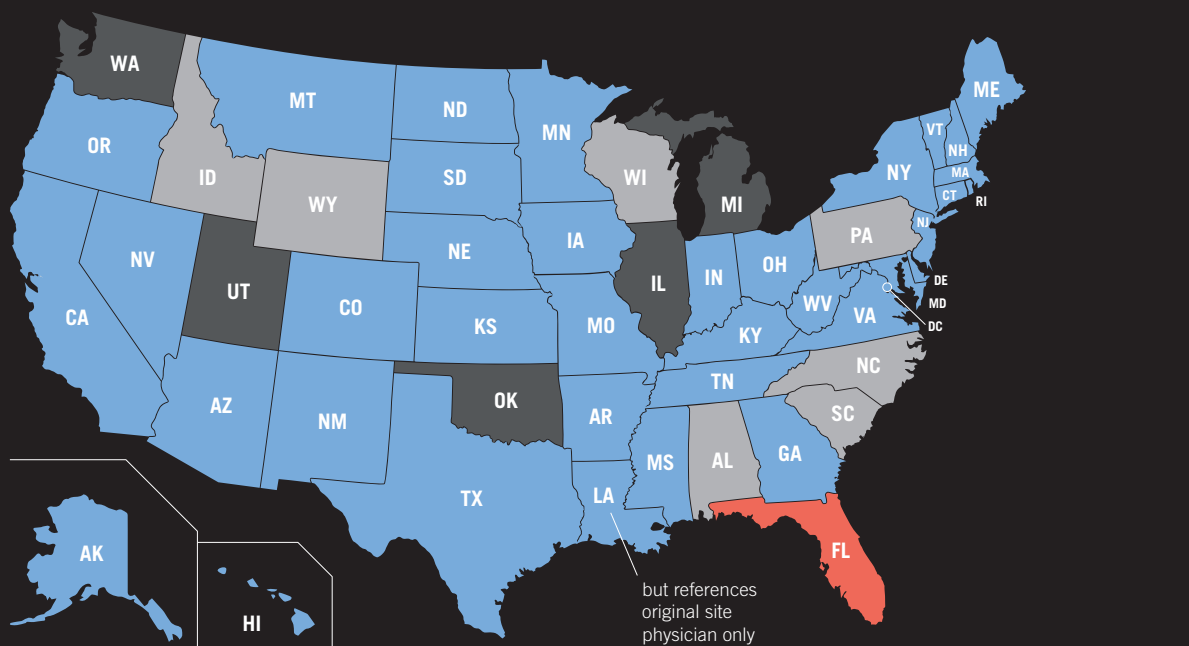
Does the State Have a Telehealth Commercial Payer Statute?

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



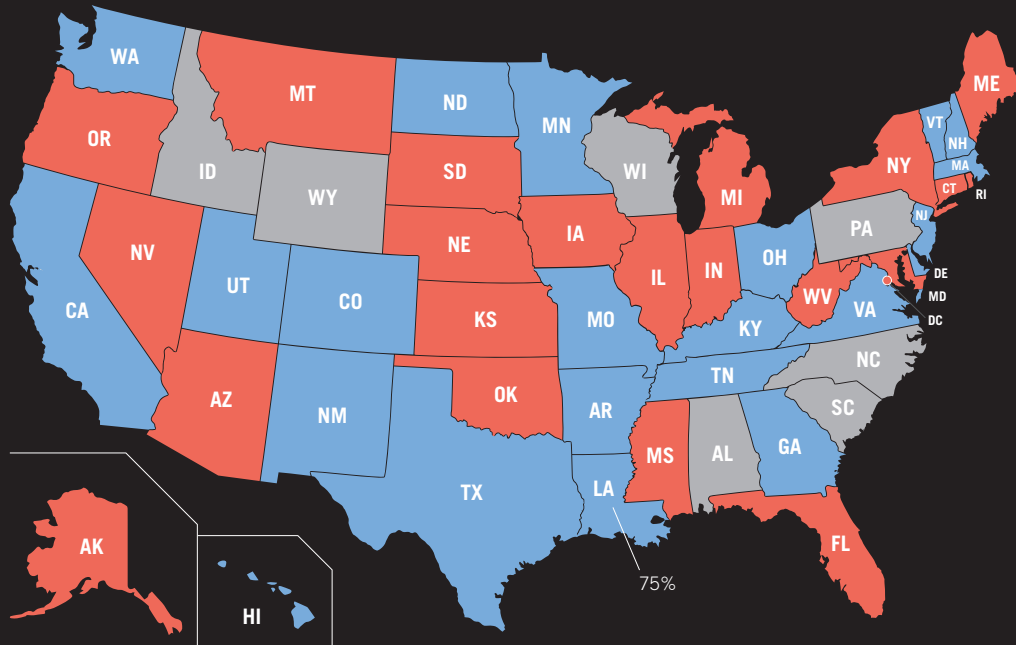
Does the Law Have a Coverage Provision?

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.)



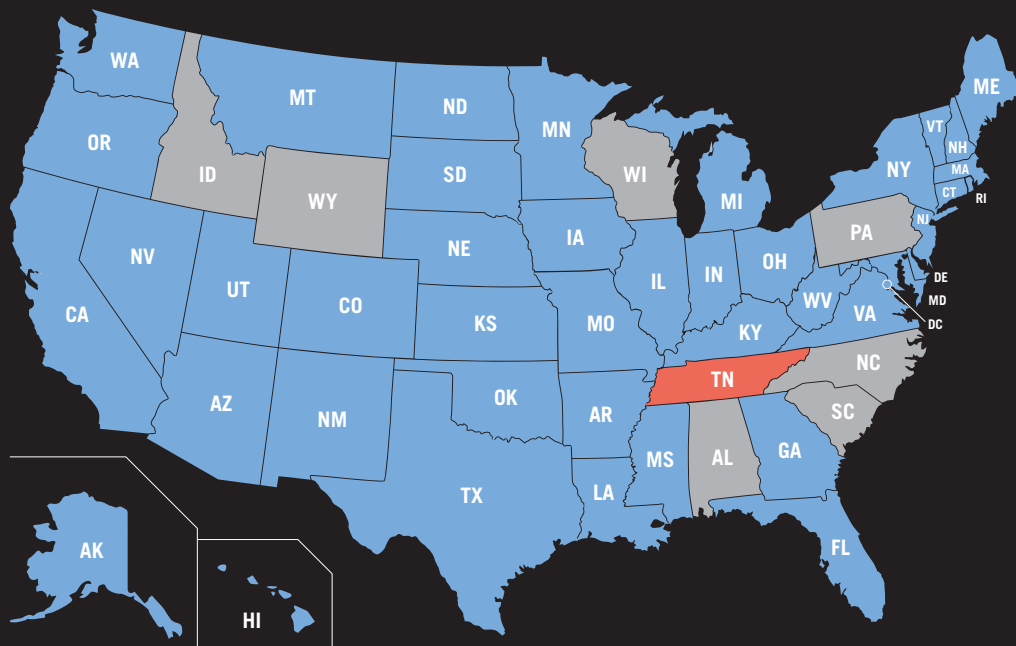
Does the Law Have a Reimbursement Provision?

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.)



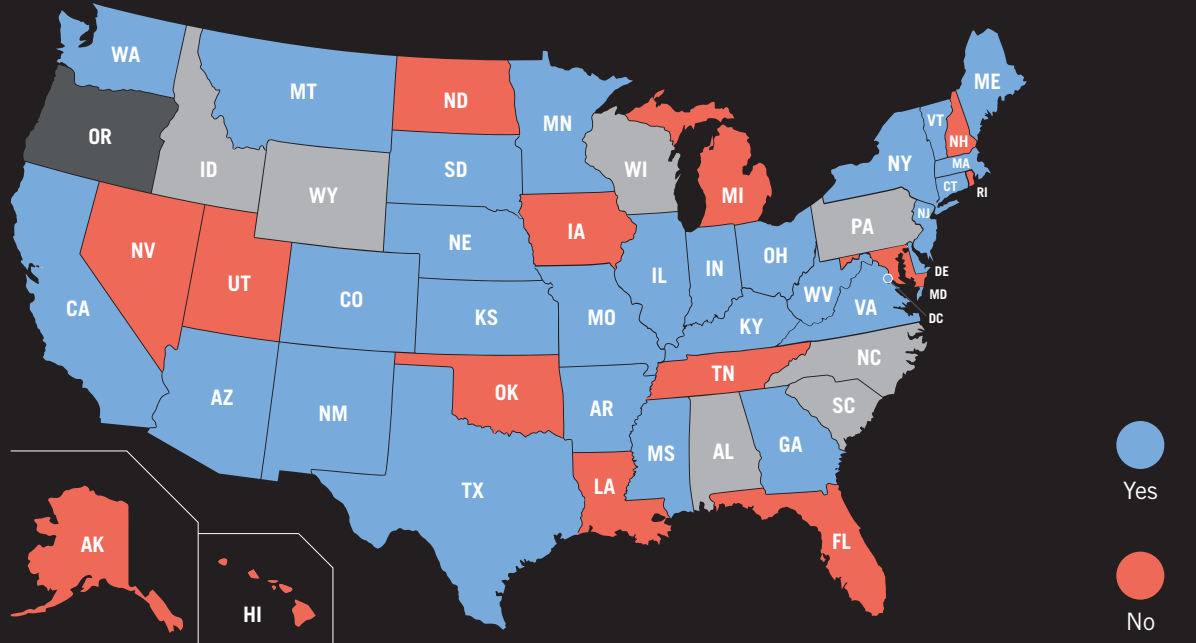
Unrestricted Originating Site?

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.



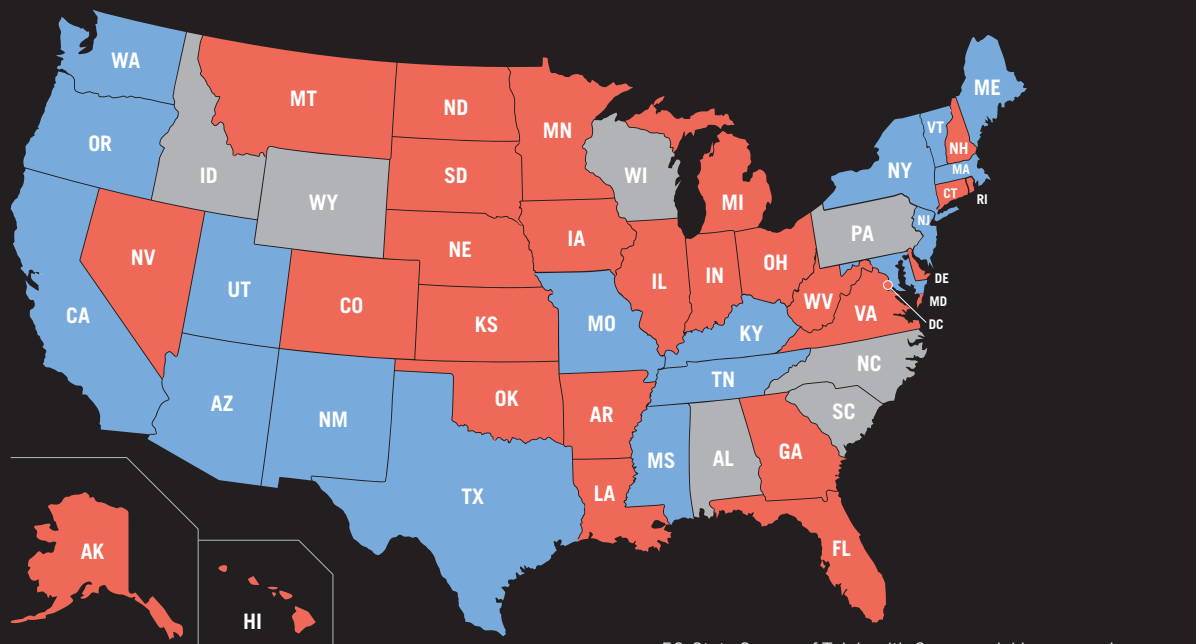
Member Cost-Shifting Protections?

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



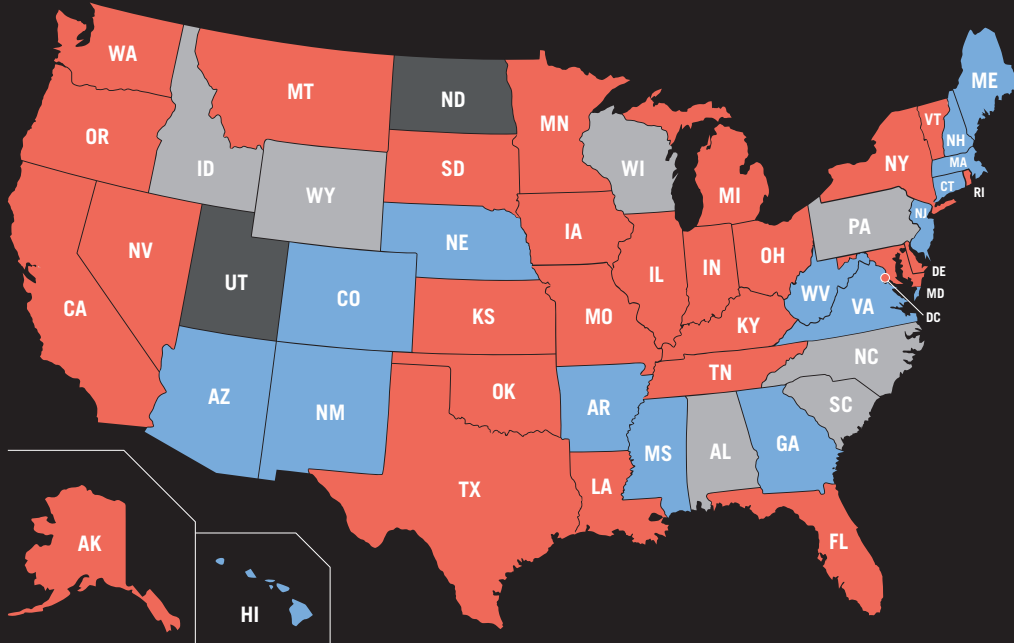
Provision for Narrow/Exclusive/In-Network Provider Limits?

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.)



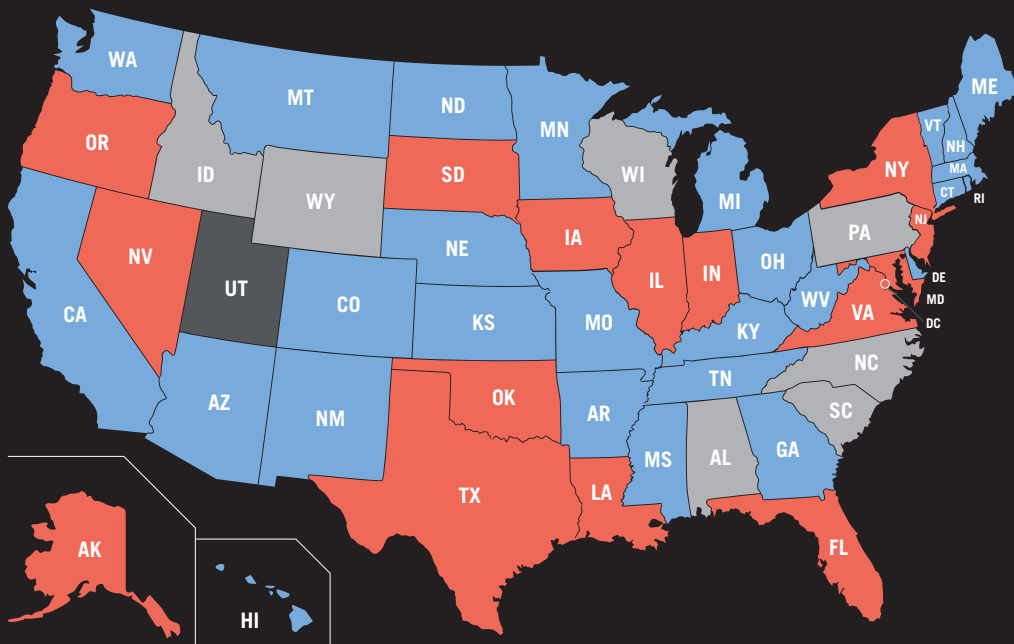
Remote Patient Monitoring?

Does the state require coverage of RPM services?



Store-and-Forward Telehealth?

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



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 co-insurance 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 co-payment, co-insurance, 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.”



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ALABAMA ALASKA

- | | | |
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| ● | ● | 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

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 (eff. Jan. 1, 2021)

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

A. All contracts issued, delivered or renewed on or after January 1, 2018 must provide coverage for health care services that are provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the subscriber and a health care provider and provided to a subscriber receiving the service in this state. A corporation may not limit or deny the coverage of health care services provided through telemedicine and may apply only the same limits or exclusions on a health care service provided through telemedicine that are applicable to an in-person consultation for the same health care service. The contract may limit the coverage to those health care providers who are members of the corporation's provider network.

B. This section does not prevent a corporation from imposing deductibles, copayment or coinsurance requirements for a health care service provided through telemedicine if the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation for the same health care service.

C. Services provided through telemedicine or resulting from a telemedicine consultation 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 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.

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

E. For the purposes of this section, "telemedicine":

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. Does not include the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail.

Ariz. Rev. Stat. § 20-1406.05 (eff. Jan. 1, 2021)

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

A. All policies issued, delivered or renewed by a group disability insurer or a blanket disability insurer on or after January 1, 2018 must provide coverage for health care services that are provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the insured and a health care provider and provided to an insured receiving the service in this state. A blanket disability insurer may not limit or deny the coverage of health care services provided through telemedicine and may apply only the same limits or exclusions on a health care service provided through telemedicine that are applicable to an in-person consultation for the same health care service. The policy may limit the coverage to those health care providers who are members of the insurer's provider network.

B. This section does not prevent a group or blanket disability insurer from imposing deductibles, copayment or coinsurance requirements for a health care service provided through telemedicine if the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation for the same health care service.

C. Services provided through telemedicine or resulting from a telemedicine consultation 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 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.

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

E. For the purposes of this section, "telemedicine":

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. Does not include the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail.

Ariz. Rev. Stat. § 20-1057.13 (eff. Jan. 1, 2021)

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

A. An evidence of coverage issued, delivered or renewed by a health care services organization on or after January 1, 2018 must provide coverage for health care services that are provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the enrollee and a health care provider and provided to an enrollee receiving the service in this state. A health care services organization may not limit or deny the coverage of health care services provided through telemedicine and may apply only the same limits or exclusions on a health care service provided through telemedicine that are applicable to an in-person consultation for the same health care service. 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. This section does not prevent a health care services organization from imposing deductibles, copayment or coinsurance requirements for a health care service provided through telemedicine if the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation for the same health care service.

C. Services provided through telemedicine or resulting from a telemedicine consultation 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 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.

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

E. For the purposes of this section, "telemedicine":

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. Does not include the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail.

Ariz. Rev. Stat. § 20-1376.05 (eff. Jan. 1, 2021)

Disability Insurance—Telemedicine; coverage of health care services; definition

A. All policies issued, delivered or renewed by a disability insurer on or after January 1, 2018 must provide coverage for health care services that are provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the insured and a health care provider and provided to an insured receiving the service in this state. A disability insurer may not limit or deny the coverage of health care services provided through telemedicine and may apply only the same limits or exclusions on a health care service provided through telemedicine that are applicable to an in-person consultation for the same health care service. The policy may limit the coverage to those health care providers who are members of the disability insurer's provider network.

B. This section does not prevent a disability insurer from imposing deductibles, copayment or coinsurance requirements for a health care service provided through telemedicine if the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation for the same health care service.

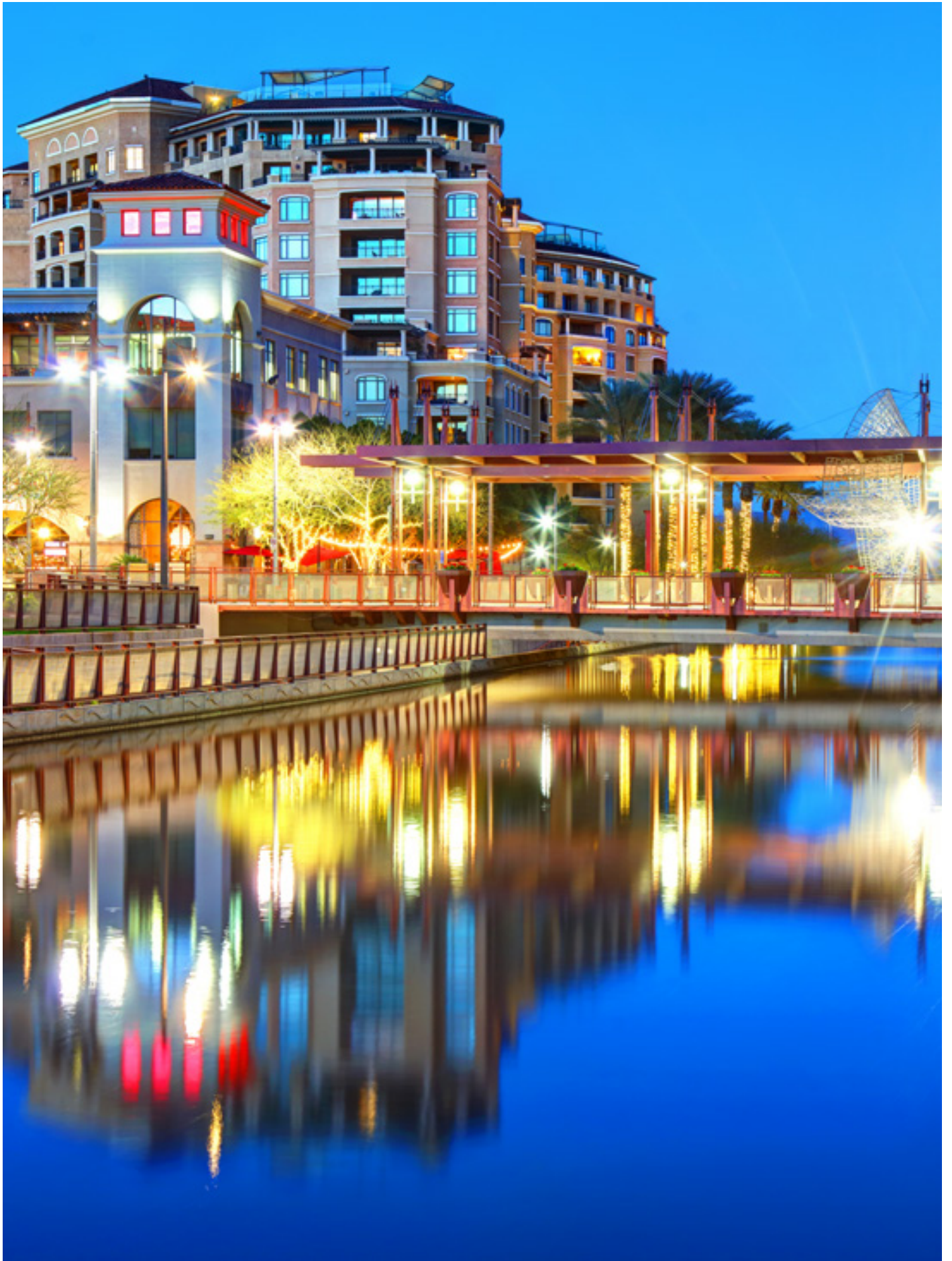
C. Services provided through telemedicine or resulting from a telemedicine consultation are subject to all of this state's laws and rules that govern prescribing, dispensing and administering prescription pharmaceuticals and devices and shall comply with Arizona licensure requirements and any practice guidelines of 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.

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

E. For the purposes of this section, "telemedicine":

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. Does not include the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail.



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, the Health Care Independence Program, commonly referred to as the “Private Option”, and the Arkansas Works 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) “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;

(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) Audio-only communication, including without limitation interactive audio;

(ii) A facsimile machine;

(iii) Text messaging; or

(iv) Electronic mail systems.

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.

(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 (changes eff. Jan. 1, 2021)

Telehealth services; requirements for health care service plan contracts

(a) (1) A contract issued, amended, or renewed on or after January 1, 2021, 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 issued, amended, or renewed on or after January 1, 2021, 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.

(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 provisions of 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.

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 (changes eff. Jan. 1, 2021)

Telehealth services; requirements for health insurance contracts

(a) (1) A contract issued, amended, or renewed on or after January 1, 2021, 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, amended, or renewed on or after January 1, 2021, 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.

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 shall 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.

(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 shall not be construed to 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.

“We predict that, given the proliferation of new telehealth services and startup companies launched in 2020, increased privacy regulation is likely to occur in 2021.”



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) The requirements of this section apply to all health benefit plans delivered, issued for delivery, amended, or renewed in this state on or after January 1, 2017, or at any time after that date when a term of the plan is changed or a premium adjustment is made.

(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 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-526, 19a-906

Conn. Gen. Stat. § 38a-499a

Individual Health Insurance—Coverage for telehealth services

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

(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. 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 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-526

Group Health Insurance—Coverage for telehealth services

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

(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. 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 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-906¹

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.

(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.

¹Note: Effective July 31, 2020 until March 15, 2021, Connecticut’s HB 6001 temporarily amended provision Conn. Gen. Stat. Ann. § 19a-906 to impose additional coverage mandates and patient cost-shifting protections. Insurers cannot exclude coverage because it is provided through telehealth or a telehealth platform selected by an in-network telehealth provider.

(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 shall charge a facility fee for telehealth services.

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

18 Del. Code § 3370

Health Insurance Contracts—Telemedicine

(a) As used in this section:²

(1) “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 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 him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, 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 described in regulation.

(5) “Telemedicine” means a form of telehealth which is the delivery of clinical health care services 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 practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the State, while such patient is at an originating site and the health care provider is at a distant site.

(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.

²Note: Effective July 17, 2020 until July 1, 2021, HB 348 temporarily amended the definitions of “telehealth” and “telemedicine” to explicitly provide that a health insurer must not require the use of visual technology in order for a telehealth service to be covered and to define “originating site” to include a site outside of Delaware if the patient is a Delaware resident.

(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 § 3571R³

Group and Blanket Health Insurance—Telemedicine

(a) As used in this section:

(1) “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 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 him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, 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 described in regulation.

(5) “Telemedicine” means a form of telehealth which is the delivery of clinical health-care services 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 practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health-care provider is at a distant site.

(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

³Note: Effective July 17, 2020 to July 1, 2021, temporary amendments apply to this provision, as described in the previous footnote.

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 him or her by means of telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, 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 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.

“Telehealth” means the use of information and communications technologies consisting of telephones, store and forward transfers, 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 services.

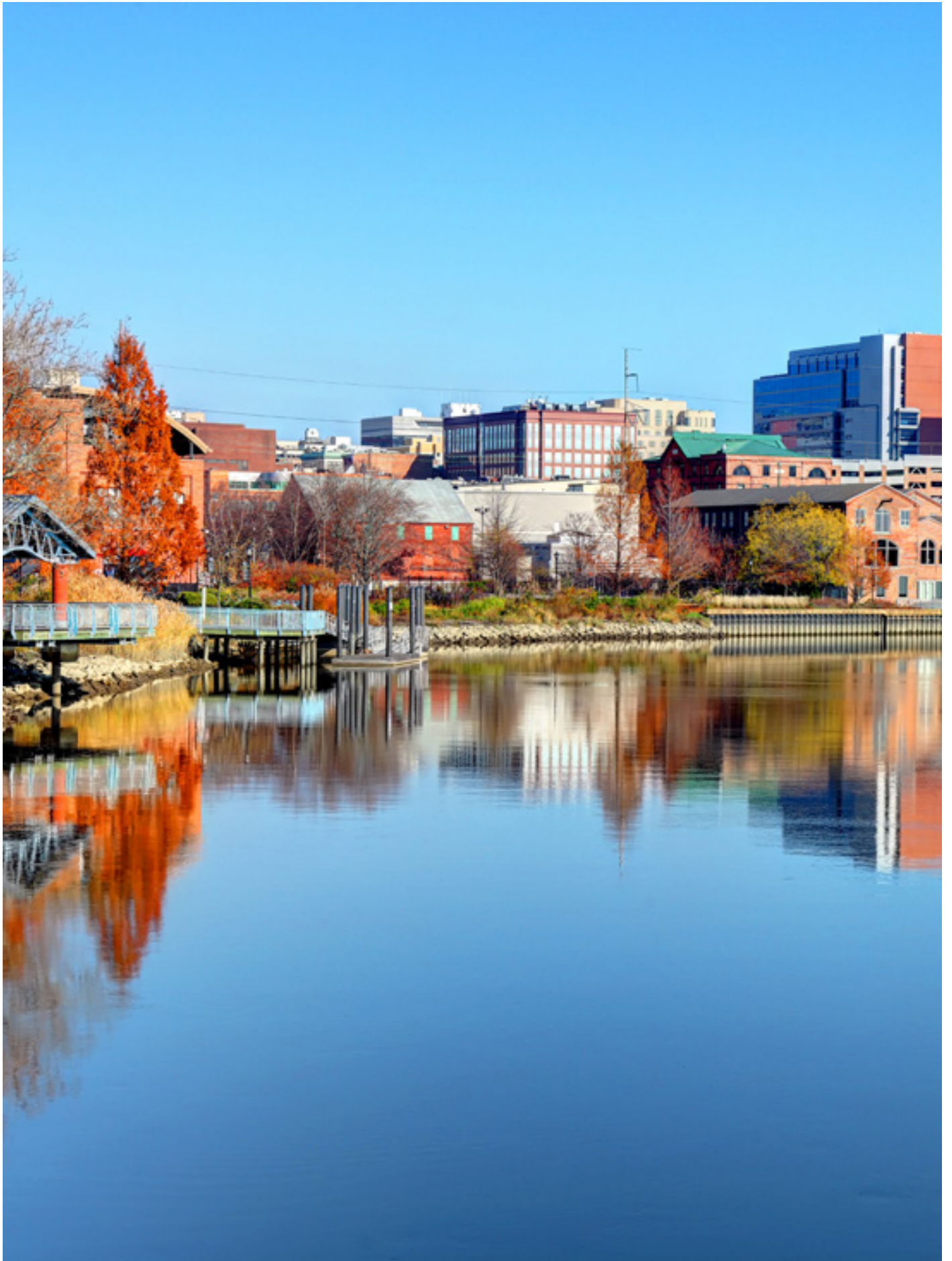
“Telemedicine” means a form of telehealth which is the delivery of clinical health-care services by means of real time 2-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide 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 practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the State, while such patient is at an originating site and the health-care provider is at a distant site.⁴

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.

⁴Note: Effective November 11, 2020, Delaware’s insurance commissioner temporarily amended the definition of “telehealth” and “telemedicine” under the insurance regulations to be consistent with the statutory amendment. See 18 Del. Admin. Code 1409-2.0. This amendment shall expire on July 1, 2021, unless extended by order of the insurance commissioner.



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.⁵
- (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 audio-only telephones, electronic mail messages, or facsimile transmissions are not included.⁶

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.

⁵Text of (2A) applicable upon the date of inclusion of its fiscal effect in an approved budget and financial plan.

⁶Note: The exclusion on the use of audio-only telephones in D.C. Code § 31-3861(4) has been temporarily stricken and replaced with the phrase “through email messages or facsimile,” until January 17, 2021. See Act A23-0426 § 5042.

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. § 627.42396⁷

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 audio-only telephone calls, 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 or part II 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).

⁷Florida’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.

(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.

(4) ‘Originating site’ means a site in this state at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; 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, 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.

(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) 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 a health care provider or telemedicine company to accept more reimbursement than they are willing to charge. 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.

(g) No insurer 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 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.

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

(i) 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.



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



Limited



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 face-to-face contact with the health care provider.

(b) No accident and health or sickness insurance plan that is issued, amended or renewed shall require face-to-face 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 shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. 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.

“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. Standard telephone contacts, facsimile transmissions or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this 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 face-to-face contact with the health care provider.

(b) No health maintenance organization plan that is issued, amended, or renewed shall require face-to-face 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 shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. 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.

“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. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter.

Haw. Rev. Stat. § 453-1.3

Practice of telehealth

[...] (h) Reimbursement for behavioral health services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient.



IDAHO

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

Idaho

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

Illinois

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

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

Coverage for telehealth services

(a) For purposes of this Section:

“Distant site” means the location at which the health care provider rendering the telehealth service is located.

“Interactive telecommunications system” means an audio and video system permitting 2-way, live interactive communication between the patient and the distant site health care provider.

“Telehealth services” means the delivery of covered health care services by way of an interactive telecommunications system.

(b) If an individual or group policy of accident or health insurance provides coverage for telehealth services, then it must comply with the following:

(1) An individual or group policy of accident or health insurance providing telehealth services may not:

(A) require that in-person contact occur between a health care provider and a patient;

(B) require the health care provider to document a barrier to an in-person consultation for coverage of services to be provided through telehealth;

(C) require the use of telehealth when the health care provider has determined that it is not appropriate; or

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

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

(b-5) If an individual or group policy of accident or health insurance provides coverage for telehealth services, it must provide coverage for licensed dietitian nutritionists and certified diabetes educators who counsel senior diabetes patients in the senior diabetes patients’ homes to remove the hurdle of transportation for senior diabetes patients to receive treatment.

(c) Nothing in this Section shall be deemed as precluding a health insurer from providing benefits for other services, including, but not limited to, remote monitoring services, other monitoring services, or oral communications otherwise covered under the policy.

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 § 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, “telemedicine services” means health care services delivered by use of

interactive audio, video, or other electronic media, including the following:

- (1) Medical exams and consultations.
 - (2) Behavioral health, including substance abuse evaluations and treatment.
- (b) The term does not include the delivery of health care services by use of the following:
- (1) A telephone transmitter for transtelephonic monitoring.
 - (2) A telephone or any other means of communication for the consultation from one (1) provider to another provider.

Ind. Code § 27-8-34-6

Coverage of telemedicine services; Conditions

- (a) A policy must provide coverage for telemedicine Indiana Code 2016 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 telemedicine 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 telemedicine 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 telemedicine services may not be required.

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 telemedicine service that is not a covered health care service under the policy.
- (2) Require the use of telemedicine services when the treating provider has determined that telemedicine services are inappropriate.
- (3) Prevent the use of utilization review concerning coverage for telemedicine 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 Telemedicine Services Required

- (a) An individual contract or a group contract must provide coverage for telemedicine 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 telemedicine 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 telemedicine 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 telemedicine 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 telemedicine services are inappropriate.
 - (3) Prevent the use of utilization review concerning coverage for telemedicine 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 telemedicine services may not be required.



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. “Health care professional” means the same as defined in section 514J.102.
 - b. “Health care services” means the same as defined in section 514J.102 and includes services for mental health conditions, illnesses, injuries, or diseases.
 - c. “Telehealth” means the delivery of health care services through the use of interactive audio and video. “Telehealth” does not include the delivery of health care services through an audio-only telephone, electronic mail message, or facsimile transmission.
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. 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.
4. 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.
5. 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.
6. 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. §§ 304.17A-138, 304.17A-005; 907 Ky. Admin. Regs. 3:170

Ky. Rev. Stat. § 304.17A-138

Telehealth coverage and reimbursement; requirements for health benefit plan; benefits subject to deductible, copayment, or coinsurance payment subject to provider network arrangements; administrative regulations

(1) (a) A health benefit plan shall reimburse for covered services provided to an insured person through telehealth as defined in KRS 304.17A-005. Telehealth coverage and reimbursement shall be equivalent to the coverage for the same service provided in person unless the telehealth provider and the health benefit plan contractually agree to a lower reimbursement rate for telehealth services.

(b) A health benefit plan 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.

(2) A health benefit plan shall require a telehealth provider to be licensed in Kentucky in order to receive reimbursement for telehealth services.

(3) 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.

(4) 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.

(5) Payment made under this section may be consistent with any provider network arrangements that have been established for the health benefit plan.

(6) 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.

Ky. Rev. Stat. § 304.17A-005

Definitions

[...](47) “Telehealth”:

(a) Means the delivery of health care-related services by a health care provider who is licensed in Kentucky to a patient or client through a face-to-face encounter with access to real-time interactive audio and video technology or store and forward services that are provided via asynchronous technologies as the standard practice of care where images are sent to a specialist for evaluation. The requirement for a face-to-face encounter shall be satisfied with the use of asynchronous telecommunications technologies in which the health care provider has access to the patient’s or client’s medical history prior to the telehealth encounter;

(b) Shall not include the delivery of services through electronic mail, text chat, facsimile, or standard audio-only telephone call; and

(c) 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.

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?

* references original site physician only

** 75%



Yes



No



Limited



N/A

Louisiana

Authorities: La. Stat. § 22:1821; La. Stat. § 22:1841-44; 46 La. Admin. Code Pt XLV, 7503

La. Stat. § 22:1821

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

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 such policy provides for payment, benefit or reimbursement for any health care service, including but not limited to diagnostic testing, treatment, referral or consultation, and such health care service is performed via transmitted electronic imaging or telemedicine, such a payment, benefit or reimbursement under such policy or contract shall not be denied to a licensed physician conducting or participating in the transmission at the originating health care facility or terminus who is physically present with the individual who is the subject of such 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 such a 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 health care service proposed to be performed or performed via transmitted electronic imaging or telemedicine under 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 telemedicine 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.

La. Stat. § 22:1841 (eff. Jan. 1, 2021)

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 telemedicine medical service or 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).

(6) “Telemedicine” shall have the same meaning as defined in R.S. 37:1262, may be provided as described in R.S. 37:1271(B)(4), and may include audio-only conversations as provided for in R.S. 37:1271(B)(4)(b)⁸.

La. Stat. § 22:1842 (eff. Jan. 1, 2021)

Telemedicine medical services and 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 telemedicine medical services, 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 telemedicine medical services or telehealth healthcare services.

La. Stat. § 22:1843 (eff. Jan. 1, 2021)

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 telemedicine or 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 telemedicine or telehealth encounter that may indicate the need for a change in the plan of care.

⁸ Note, this may be a drafting error given that audio-only is not permitted under LSA-R.S. 37:1271. LSA-R.S. 37:1271 (B)(4)(b) provides “A physician practicing 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 is able to meet the same standard of care as if the healthcare services were provided in person.” (Emphasis supplied).

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

(i) Teaching regarding medication management as appropriate based on the telemedicine or 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 telemedicine or 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.

(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 (eff. Jan. 1, 2021)

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.

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.

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. Rev. Stat. tit. 24-A, § 4316

(eff. Jan. 1, 2020)

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.

C. “Telehealth,” as it pertains to the delivery of health care services, means the use of interactive real-time visual and audio or other electronic media for the purpose of consultation and education concerning and diagnosis, treatment, care management and self-management of an enrollee’s physical and mental health and includes real-time interaction between the enrollee and the telehealth provider, synchronous encounters, asynchronous encounters, store and forward transfers and telemonitoring. “Telehealth” does not include the use of audio-only telephone, facsimile machine, e-mail or texting.

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 through the use of clinical data while the enrollee remains in a residential setting, allowing the provider to track the enrollee’s health data over time. Telemonitoring may or may not take place in real time.

E. “Telephonic services,” as it pertains to the delivery of health care services, means the use of telephone communication by a provider at a distance for the purpose of diagnosis, disease monitoring or treatment.

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. 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.

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 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.

5. Coverage for telephonic services. A carrier shall provide coverage for telephonic services when scheduled telehealth services are technologically unavailable at the time of the scheduled telehealth service for an existing enrollee and the telephonic services are medically appropriate for the corresponding covered health care services.

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).



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, Ins. § 15-139

Health care services delivered through telemedicine

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 the delivery of mental health care services to a patient in the patient’s home setting.

(3) “Telehealth” does not include:

(i) 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; and

(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.

(2) The health care services appropriately delivered through telehealth shall include counseling for substance use disorders.

Reimbursement to health care provider for services delivered through telehealth

(d) An entity subject to this section:

(1) 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;

(2) is not required to:

(i) 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

(ii) reimburse a health care provider who is not a covered provider under the health insurance policy or contract; and

(3)(i) 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;

(ii) may impose an annual dollar maximum as permitted by federal law; and

(iii) may not impose a lifetime dollar maximum.

Utilization review to determine appropriateness of health care service

(e) An entity subject to this section may undertake utilization review, including preauthorization, to determine the appropriateness of any health care service whether the service is delivered through an in-person consultation or through telehealth if the appropriateness of the health care service is determined in the same manner.

Policies or contracts not to distinguish between patients in rural or urban locations

(f) 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

(g) 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 (applying to individual accident and sickness insurance); M.G.L.A. 176A § 38 (applying to nonprofit hospital service corporation plans); M.G.L.A. 176B § 25 (applying to medical service corporations); M.G.L.A. 176G § 33 (applying to health maintenance organizations); M.G.L.A. 176I § 13 (applying to a preferred provider organization contract); M.G.L.A. 32A § 30 (applying to contributory group general or blanket insurance contracts for government employees); M.G.L.A. 176O §§ 1, 6 (health insurance consumer protections); S2984, §§ 68, 69 (not codified; providing payment parity)

M.G.L.A. 175 § 47MM⁹

(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 providers¹⁰.

(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 provided via telehealth as long as the deductible, copayment or coinsurance does not

⁹ Note: A final version of the Massachusetts bill has not been codified. Thus, the quoted provisions in this report may be subject to change. 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).

¹⁰ Note: Until the termination of the Massachusetts governor’s March 10, 2020 declaration of a state of emergency, network adequacy may be met through significant reliance on telehealth providers. See Section 66 of S2984.

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.

M.G.L.A. 1760 § 1

Health Insurance Consumer Protections—Definitions

As used in this chapter, the following words shall 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.

[...]

“Chronic disease management”, care and services for the management of chronic conditions, as defined by the federal Centers for Medicare and Medicaid Services, that include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, cancer and coronary artery disease.

[...]

“Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who: (i) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii) maintains continuity of care within the scope of practice.

“Primary care services”, services delivered by a primary care provider.



M.G.L.A. 1760 § 6

Health Insurance Consumer Protections—Evidence of coverage to be delivered to covered adults by health, dental and vision care providers; contents

(a) A carrier shall issue and deliver to at least one adult insured in each household residing in the commonwealth, upon enrollment, an evidence of coverage and any amendments thereto. Said evidence of coverage shall contain a clear, concise and complete statement of:

[...]

(4) the locations where, and the manner in which, health care services and other benefits may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier shall cover the out-of-network admission, procedure or service and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures or services offered within the carrier's network; and (ii) an explanation that whenever a location is part of the carrier's network, that the carrier shall cover medically necessary covered benefits delivered at that location and the insured shall not be responsible to pay more than the amount required for network services even if part of the medically necessary covered benefits are performed by out-of-network providers unless the insured has a reasonable opportunity to choose to have the service performed by a network provider; and (iii) a summary description of the insured's telehealth coverage and access to telehealth services, including, but not limited to, behavioral health services, chronic disease management and primary care services via telehealth, as well as the telecommunications technology available to access telehealth services.

S2984, § 68 (not codified)¹¹

Notwithstanding any general or special law to the contrary, the group insurance commission under chapter 32A of the General Laws, the division of medical assistance under chapter 118E of the General Laws, insurance companies organized under chapter 175 of the General Laws, non-profit hospital service corporations organized under chapter 176A of the General Laws, medical service corporations organized under chapter 176B of the General Laws, health maintenance organizations organized under chapter 176G of the General Laws and preferred provider organizations organized under chapter 176I of the General Laws shall ensure that rates of payment for in-network providers for telehealth services provided pursuant to section 30 of said chapter 32A, section 79 of said chapter 118E, section 47MM of said chapter 175, section 38 of said chapter 176A, section 25 of said chapter 176B, section 33 of said chapter 176G and section 13 of said chapter 176I are not less than the rate of payment for the same service delivered via in-person methods.

S2984, § 69 (not codified)¹²

SECTION 69. Notwithstanding any general or special law to the contrary, the group insurance commission under chapter 32A of the General Laws, the division of medical assistance under chapter 118E of the General Laws, insurance companies organized under chapter 175 of the General Laws, non-profit hospital service corporations organized under chapter 176A of the General Laws, medical service corporations organized under chapter 176B of the General Laws, health maintenance organizations organized under chapter 176G of the General Laws and preferred provider organizations organized under chapter 176I of the General Laws shall ensure that the rate of payment for in-network providers of chronic disease management, as defined in section 1 of chapter 1760 of the General Laws, and primary care services, as defined in section 1 of chapter 1760 of the General Laws, delivered via telehealth pursuant to section 30 of said chapter 32A, section 79 of said chapter 118E, section 47MM of said chapter 175, section 38 of said chapter 176A, section 25 of said chapter 176B, section 33 of said chapter 176G and section 13 of said chapter 176I are not less than the rate of payment for the same service delivered via in-person methods.

¹¹ This provision will be repealed 90 days after termination of the governor's March 10, 2020 declaration of state of emergency. See §§ 77, 79 in S2984.

¹² This provision will be repealed two years from the effective date of this act. See §§ 76, 78 in S2984.

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.671-.672¹³

Minn. Stat. § 62A.671

Definitions

Subdivision 1. Applicability. For purposes of sections 62A.67 to 62A.672, the terms defined in this section have the meanings given.

Subd. 2. Distant site. “Distant site” means a site at which a licensed health care provider is located while providing health care services or consultations by means of telemedicine.

Subd. 3. Health care provider. “Health care provider” has the meaning provided in section 62A.63, subdivision 2.

Subd. 4. Health carrier. “Health carrier” has the meaning provided in section 62A.011, subdivision 2.

Subd. 5. Health plan. “Health plan” means a health plan as defined in section 62A.011, subdivision 3, and 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 policyholder.

Subd. 6. Licensed health care provider. “Licensed health care provider” means a health care provider who is:

(1) licensed under chapter 147, 147A, 148, 148B, 148E, 148F, 150A, or 153; a mental health professional as defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; or vendor of medical care defined in section 256B.02, subdivision 7; and

(2) authorized within their respective scope of practice to provide the particular service with no supervision or under general supervision.

Subd. 7. Originating site. “Originating site” means a site including, but not limited to, a health care facility at which a patient is located at the time health care services are provided to the patient by means of telemedicine.

Subd. 8. Store-and-forward technology. “Store-and-forward technology” means the transmission of a patient’s medical information from an originating site to a health care provider at a distant site without the patient being present, or the delivery of telemedicine that does not occur in real time via synchronous transmissions.

Subd. 9. Telemedicine. “Telemedicine” means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient’s health care.

¹³ The Minnesota legislature temporarily amended Minn. Stat. §§ 62A.671, 62A.672, 265B.0625 until February 1, 2021. See Laws 2020, ch. 70, art. 3, § 1, providing:

(a) The definition of “originating site” under Minnesota Statutes, section 62A.671, subdivision 7, includes a patient’s residence if the patient is receiving health care services or consultations by means of telemedicine.

(b) The definition of “telemedicine” under Minnesota Statutes, section 62A.671, subdivision 9, includes health care services or consultations delivered to a patient at the patient’s residence.

(c) Under Minnesota Statutes, section 62A.672, subdivision 2, a health carrier shall not exclude or reduce coverage for a health care service or consultation solely because the service or consultation is provided via telemedicine directly to a patient at the patient’s residence.

(d) “Telemedicine” as defined in Minnesota Statutes, section 256B.0625, subdivision 3b, paragraph (d), includes the delivery of health care services or consultations with a patient at the patient’s residence and the licensed health care provider at a distant site.

Other emergency statutes relating to telemedicine are coterminous with the end of the state of emergency and are beyond the scope of this report. See, e.g., Laws 2020, ch. 74, art. 1, § 15.

Minn. Stat. § 62A.672

Coverage of telemedicine services

Subdivision 1. Coverage of telemedicine. (a) A health plan sold, issued, or renewed by a health carrier for which coverage of benefits begins on or after January 1, 2017, shall include coverage for telemedicine benefits in the same manner as any other benefits covered under the policy, plan or contract, and shall comply with the regulations of this section.

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

(1) require a health carrier to provide coverage for services that are not medically necessary;

(2) prohibit a health carrier from establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service via telemedicine for which the health carrier does not already reimburse other health care providers for delivering via telemedicine, so long as the criteria are not unduly burdensome or unreasonable for the particular service; or

(3) prevent a health carrier from requiring a health care provider to agree to certain documentation or billing practices designed to protect the health carrier or patients from fraudulent claims so long as the practices are not unduly burdensome or unreasonable for the particular service.

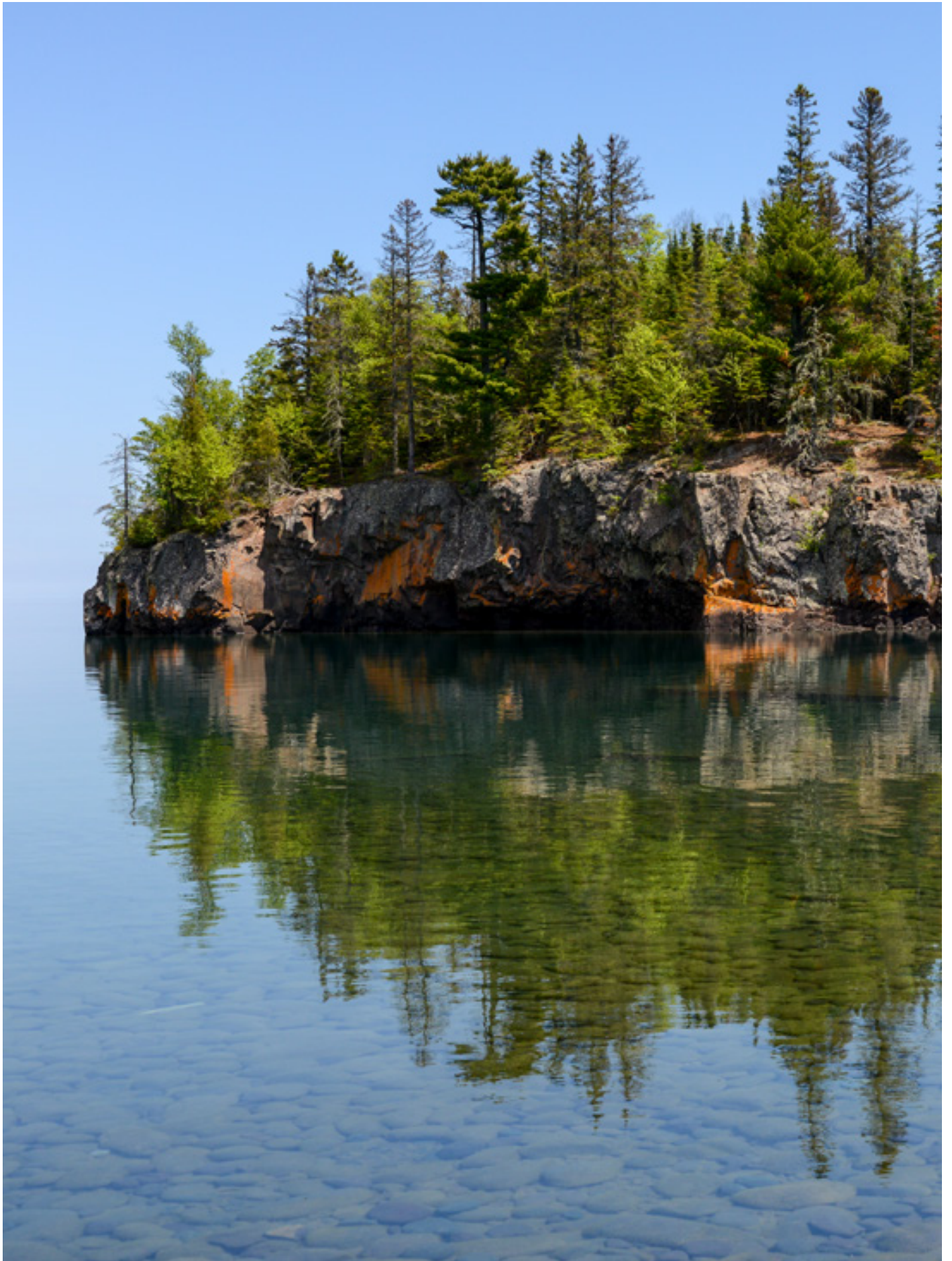
Subd. 2. Parity between telemedicine and in-person services. A health carrier shall not exclude a service for coverage solely because the service is provided via telemedicine and is not provided through in-person consultation or contact between a licensed health care provider and a patient.

Subd. 3. Reimbursement for telemedicine services.

(a) A health carrier shall reimburse the distant site licensed health care provider for covered services delivered via telemedicine on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered in person by the distant site licensed health care provider.

(b) It is not a violation of this subdivision for a health carrier to include a deductible, copayment or coinsurance requirement for a health care service provided via telemedicine, provided that 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.





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 Ann. § 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 interactive audio, video or other electronic media. Telemedicine must be “real-time” consultation, and it does not include the use of audio-only telephone, e-mail or facsimile.

(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.

(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) A health insurance or employee benefit plan may limit coverage to health care providers in a telemedicine network approved by the plan.

(5) 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.

(6) 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.

(7) The originating site is eligible to receive a facility fee, but facility fees are not payable to the distant site.

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;

(b) Have a recent history of costly service use due to one or more chronic conditions as evidenced by two (2) or more hospitalizations, including emergency room visits, in the last twelve (12) months; 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 must be submitted to request telemonitoring services. The request 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 telemedicine 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 telemedicine if the services are otherwise covered by the policy, certificate, contract or agreement.

(2) 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.

(3) 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; or

(b) 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 telemedicine determines that the presence of a health care provider is necessary.

(4) 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 telemedicine.

(5) This section does not apply to disability income, hospital indemnity, Medicare supplement, specified disease or long-term care policies.

(6) 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 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) "Store-and-forward technology" means electronic information, imaging and communication that is transferred, recorded or otherwise stored in order to be reviewed at a later date by a health care provider or health care facility at a distant site without the patient present in real time. The term includes interactive audio, video and data communication.

(d)(i) "Telemedicine" means the use of interactive audio, video or other telecommunications technology that is:

(A) used by a health care provider or health care facility to deliver health care services at a site other than the site where the patient is located; and

(B) delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, et seq.

(ii) The term includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.

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 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

(1) For purposes of this section:

(a) Telehealth means the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care provider in the diagnosis or treatment of a patient. Telehealth includes services originating from a patient's home or any other location where such patient is located, asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to or retrieved by a health care provider at another site for medical evaluation, and telemonitoring; 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;

(c) Requirements for the licensing status of health care providers providing telehealth and telemonitoring services; and

(d) Requirements for demonstrating compliance with the signed written statement requirement in section 71-8505.

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 (for individual health insurance policies); Nev. Rev. Stat. § 689B.0369 (for group and blanket health policies); Nev. Rev. Stat. § 689C.195 (for small employer health benefit plans); Nev. Rev. Stat. § 616C.730 (for industrial insurance); Nev. Rev. Stat. § 695A.265 (for fraternal benefit societies); Nev. Rev. Stat. § 695B.1904 (for nonprofit corporations for hospital, medical and dental service contracts); Nev. Rev. Stat. § 695C.1708 (for health maintenance organizations); Nev. Rev. Stat. § 695D.216 (for dental plans); Nev. Rev. Stat. § 695G.162 (for managed care organizations); Nev. Rev. Stat. § 629.515 (providing definitions ascribed by above referenced statutes).

Nev. Rev. Stat. § 689A.0463

Coverage for services provided through telehealth; prohibited actions by insurer; exclusions

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. 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;
 - (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;
 - (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 insured 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 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.

4. 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.
5. 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, 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" has the meaning ascribed to it in NRS 629.515.

Nev. Rev. Stat. § 689B.0369

Required provision concerning coverage for services provided through telehealth

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. 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;

(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;

(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 insured 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 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.

4. 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.

5. 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, 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” has the meaning ascribed to it in NRS 629.515.



Nev. Rev. Stat. § 689C.195

Coverage for services provided through telehealth

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 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;
 - (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;
 - (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 insured 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 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.
4. 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.
5. A plan subject to the provisions of this chapter 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 plan 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” 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" has the meaning ascribed to it in NRS 629.515.

Nev. Rev. Stat. § 695A.265

Coverage for services provided through telehealth

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 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;

(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;

(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 insured 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 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.

4. 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.

5. A benefit contract subject to the provisions of this chapter 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 contract 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" has the meaning ascribed to it in NRS 629.515.

Nev. Rev. Stat. § 695B.1904

Required provision concerning coverage for services provided through telehealth

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 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;

(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;

(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 insured 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 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.

4. 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.

5. 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, 2015, 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.

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" has the meaning ascribed to it in NRS 629.515.

Nev. Rev. Stat. § 695C.1708

Required provision concerning coverage for services provided through telehealth

1. A health care plan of a health maintenance organization must include coverage for services provided to an enrollee through telehealth to the same extent as though provided in person or by other means.

2. 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;

(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;

(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 enrollee 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 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.

4. 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.

5. Evidence of coverage subject to the provisions of this chapter 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 plan 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" has the meaning ascribed to it in NRS 629.515.

Nev. Rev. Stat. § 695D.216

Required provision concerning coverage for services provided through telehealth

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. 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;

(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;

(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 a member 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 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.

4. 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.

5. 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, 2015, 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.

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" has the meaning ascribed to it in NRS 629.515.

Nev. Rev. Stat. § 695G.162

Required provision concerning coverage for services provided through telehealth

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 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;

(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;

(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 insured 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 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.

4. 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.

5. Evidence of coverage 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 plan 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" 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

4. 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.

(c) "Telehealth" means the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail.



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. 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.

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:

"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).

"Health benefits plan" means the same as that term is defined by section 2 of P.L.1997, c. 192 (C.26:2S-2).

"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).

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. 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.

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:

“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).

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. 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.

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:

“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).

N.J. Stat. § 45:1-61

Telemedicine and Telehealth—Definitions

[...]

“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, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission. [...]



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 (for group health coverage, including any form of self-insurance); N.M. Stat. § 59A-46-50.3 (for individual or group health maintenance organization contracts); N.M. Stat. § 59A-22-49.3 (for individual or group health insurance policy, health care plan or certificate of health insurance); N.M. Stat. § 59A-23-7.12 (for blanket or group health insurance policy); N.M. Stat. § 59A-47-45.3 (for individual or group nonprofit health care plan policies)

N.M. Stat. Ann. § 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 (applying to life, accident and health insurance contracts); N.Y. Pub. Health Law § 4406-g (applying to health maintenance organizations); N.Y. Ins. Law § 4306-g (applying to insurance provided under non-profit medical or health and hospital service corporations);

N.Y. Ins. Law § 3217-h

Insurance Contracts—Life, Accident and Health Annuities—Telehealth delivery of services

(a) 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.

(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.

N.Y. Ins. Law § 4306-g.

Non-Profit Medical and Dental Indemnity, or Health and Hospital Service Corporations—Telehealth delivery of services

(a) 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.

(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

NORTH DAKOTA

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

* telehome monitoring



Yes



No



Limited



N/A

North Carolina

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

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. "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.

c. "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.

d. "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.

e. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.

f. "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.

g. "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 audio-only telephone, electronic mail, or facsimile transmissions.

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 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. Stat. § 3902.30

Ohio Rev. Code § 3902.30

Telemedicine services coverage; basis and extent

(A) As used in this section:

(1) “Health benefit plan,” “health care services,” and “health plan issuer” have the same meanings as in section 3922.01 of the Revised Code.

(2) “Health care professional” means any of the following:

(a) A physician licensed under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery;

(b) A physician assistant licensed under Chapter 4731. of the Revised Code;

(c) An advanced practice registered nurse as defined in section 4723.01 of the Revised Code.

(3) “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.

(4) “Recipient” means a patient receiving health care services or a health care professional with whom the provider of health care services is consulting regarding the patient.

(5) “Telemedicine services” means a mode of providing health care services through synchronous or asynchronous 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 the recipient is located.

(B)(1) A health benefit plan shall provide coverage for telemedicine 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 telemedicine service.

(C) A health benefit plan shall not impose any annual or lifetime benefit maximum in relation to telemedicine services other than such a benefit maximum imposed on all benefits offered under the plan.

(D) This section shall not be construed as doing any of the following:

(1) Prohibiting a health benefit plan from assessing cost-sharing requirements to a covered individual for telemedicine services, provided that such cost-sharing requirements for telemedicine services are not greater than those for comparable in-person health care services;

(2) Requiring a health plan issuer to reimburse a health care professional for any costs or fees associated with the provision of telemedicine services that would be in addition to or greater than the standard reimbursement for comparable in-person health care services;

(3) Requiring a health plan issuer to reimburse a telemedicine provider for telemedicine services at the same rate as in-person services.

(E) This section applies to all health benefit plans issued, offered, or renewed on or after January 1, 2021.

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 this act, “telemedicine” means the practice of health care delivery, diagnosis, consultation, treatment, including but not limited to, the treatment and prevention of strokes, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. Telemedicine is not a consultation provided by telephone or facsimile machine.

36 Okla. St. § 6803

Coverage of telemedicine services

A. Services that a health care practitioner 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 practitioner 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.

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.058, 743A.185

Or. Rev. Stat. § 743A.058

Coverage of health service provided using synchronous two-way interactive video conferencing

(1) As used in this section:

(a) “Health benefit plan” has the meaning given that term in ORS 743B.005.

(b) “Health professional” means a person licensed, certified or registered in this state to provide health care services or supplies.

(c) “Originating site” means the physical location of the patient.

(2) A health benefit plan must provide coverage of a health service that is provided using synchronous two-way interactive video conferencing 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 synchronous two-way interactive video conferencing 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) A health benefit plan may not distinguish between rural and urban originating sites in providing coverage under subsection (2) of this section.

(4) The coverage under subsection (2) of this section is subject to:

(a) The terms and conditions of the health benefit plan; and

(b) The reimbursement specified in the contract between the plan and the health professional.

(5) This section does not require a health benefit plan to reimburse a health professional:

(a) For a health service that is not a covered benefit under the plan; or

(b) Who has not contracted with the plan.

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

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

Pennsylvania

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

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

(2) “Health-care facility” means an institution providing health-care services or a health-care 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.

(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) “Health-care provider” means a health-care professional or a health-care facility.

(5) “Health-care 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.

(6) “Health insurer” means any person, firm, or corporation offering and/or insuring health-care services on a prepaid basis, including, but not limited to, a nonprofit service corporation, a health-maintenance organization, or an entity offering a policy of accident and sickness insurance.

(7) “Health-maintenance organization” means a health-maintenance organization as defined in chapter 41 of this title.

(8) “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.

(9) “Originating site” means a site at which a patient is located at the time health-care services are provided to them by means of telemedicine, which can be a patient’s home where medically appropriate; provided, however, notwithstanding any other provision of law, health insurers and health-care providers may agree to alternative siting arrangements deemed appropriate by the parties.

(10) “Policy of accident and sickness insurance” means a policy of accident and sickness insurance as defined in chapter 18 of this title.

(11) “Store-and-forward technology” means the technology used to enable the transmission of a patient’s medical information from an originating site to the health-care provider at the distant site without the patient being present.

(12) “Telemedicine” means the delivery of clinical health-care services by means of real time, two-way electronic audiovisual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health-care delivery, which facilitate the assessment, diagnosis, treatment, and care management of a patient’s health care while such patient is at an originating site and the health-care provider is at a distant site, consistent with applicable federal laws and regulations. Telemedicine does not include an audio-only telephone conversation, email message, or facsimile transmission between the provider and patient, or an automated computer program used to diagnose and/or treat ocular or refractive conditions.

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 health-care services and/or provides a health-care plan for health-care services shall provide coverage for the cost of such covered health-care services provided through telemedicine services, as provided in this section.

(b) A health insurer shall not exclude a health-care service for coverage solely because the health-care service is provided through telemedicine and is not provided through in-person consultation or contact, so long as such health-care services are medically appropriate to be provided through telemedicine services and, as such, may be subject to the terms and conditions of a telemedicine agreement between the insurer and the participating health-care provider or provider group.

(c) Benefit plans offered by a health insurer may impose a deductible, copayment or coinsurance requirement for a health-care service provided through telemedicine.

(d) 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.

(e) 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**

**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 Carolina

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

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 Accessibility 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) 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; and

(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;

(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.

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) This section is repealed on 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

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) “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 physician in providing telemedicine medical services that are delegated and supervised by the physician; or

(C) a licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service.

(2) “Physician” means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.1

(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) “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 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 or telehealth service.

(c) Notwithstanding Subsection (a), a health benefit plan is not required to provide coverage for a telemedicine medical 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 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 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 or telehealth services.

Tex. Occ. Code § 111.001

Definitions

(1) "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.

(3) "Telehealth service" means a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

(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, 26-60-102

Utah Code § 31A-22-649.5

Insurance parity for telemedicine services

(1) As used in this section:

(a) “Telehealth services” means the same as that term is defined in Section 26-60-102.

(b) “Telemedicine services” means the same as that term is defined in Section 26-60-102.

(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 and entered into or renewed on or after January 1, 2021, shall:

(a) provide coverage for telemedicine services that are covered by Medicare; and

(b) reimburse, at a commercially reasonable rate, a network provider that provides the telemedicine services described in Subsection (2)(a).

(3) Notwithstanding Section 31A-45-303, a health benefit plan providing treatment under Subsection (2) may not impose originating site restrictions, geographic restrictions, or distance-based restrictions.

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 26-60-102.

(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 § 26-60-102

Definitions

As used in this chapter:

(1) “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.

(2) “Distant site” means the physical location of a provider delivering telemedicine services.

(3) “Originating site” means the physical location of a patient receiving telemedicine services.

(4) “Patient” means an individual seeking telemedicine services.

(5)(a) “Patient-generated medical history” means medical data about a patient that the patient creates, records, or gathers.

(b) “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.

(6) “Provider” means an individual who is:

(a) licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act;

(b) licensed under Title 58, Occupations and Professions, to provide health care; or

(c) licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities.

(7) “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.

(8) “Telehealth services” means the transmission of health-related services or information through the use of electronic communication or information technology.

(9) “Telemedicine services” means telehealth services:

(a) including:

(i) clinical care;

(ii) health education;

(iii) health administration;

(iv) home health;

(v) facilitation of self-managed care and caregiver support; or

(vi) remote patient monitoring occurring incidentally to general supervision; and

(b) provided by a provider to a patient through a method of communication that:

(i)(A) uses asynchronous store and forward transfer; or

(B) uses synchronous interaction; and

(ii) meets industry security and privacy standards, including compliance with:

(A) the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended; and

(B) the federal Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 226, 467, as amended.



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

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 to services provided pursuant to the health insurance plan's contract with a third-party telemedicine vendor to provide health care or dental services.

(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.

(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.



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.

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 (insurance expansion eff. Jan. 1, 2021), 41.05.700 (state employee health plans), 71.24.335 (behavioral health administrative services organizations and managed care organizations).

Wash. Rev. Code § 48.43.735

(expansion eff. Jan. 1, 2021)

Insurance Reform—Reimbursement of health care services provided through telemedicine or store and forward technology

(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; and

(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.

(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 at the same rate as 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 a reimbursement rate for telemedicine services that differs from the reimbursement rate 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) Community mental health center;

(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 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.

(d) "Originating site" means the physical location of a patient receiving health care services through telemedicine;

(e) "Provider" has the same meaning as in RCW 48.43.005;

(f) "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

(g) “Telemedicine” means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation or treatment. For purposes of this section only, “telemedicine” does not include the use of audio-only telephone, facsimile, or email.

Wash. Rev. Code § 41.05.700

State Health Care Authority—Reimbursement of health care services provided through telemedicine or store and forward technology

(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; and

(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.

(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 at the same rate as 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 a reimbursement rate for telemedicine services that differs from the reimbursement rate 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) Community mental health center;

(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 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) For purposes of this section:

(a) “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;

(b) “Health care service” has the same meaning as in RCW 48.43.005;

(c) “Hospital” means a facility licensed under chapter 70.41, 71.12, or 72.23 RCW;

(d) “Originating site” means the physical location of a patient receiving health care services through telemedicine;

- (e) “Provider” has the same meaning as in RCW 48.43.005;
- (f) “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
- (g) “Telemedicine” means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, “telemedicine” does not include the use of audio-only telephone, facsimile, or email.

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

- (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 who is under eighteen years old 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; and
- (b) The behavioral health service is medically necessary.
- (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 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) For purposes of this section:
- (a) “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;
- (b) “Hospital” means a facility licensed under chapter 70.41, 71.12, or 72.23 RCW;
- (c) “Originating site” means the physical location of a patient receiving behavioral health services through telemedicine;
- (d) “Provider” has the same meaning as in RCW 48.43.005;
- (e) “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
- (f) “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.
- (9) 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) “Health care practitioner” means a person licensed under § 30-1-1 et seq. of this code who provides health care services.

(3) “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.

(4) “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.

(5) “Telehealth services” means the use of synchronous or asynchronous telecommunications technology 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 include audio-only telephone calls, e-mail messages, or facsimile transmissions.

(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 shall provide reimbursement for a telehealth service at a rate negotiated between the provider and the insurance company.

(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 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 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) "Health care practitioner" means a person licensed under § 30-1-1 et seq. of this code who provides health care services.

(3) "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.

(4) "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.

(5) "Telehealth services" means the use of synchronous or asynchronous telecommunications technology 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 include audio-

only telephone calls, e-mail messages, or facsimile transmissions.

(b) After July 1, 2020, 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.

(c) After July 1, 2020, the plan may not exclude a service for coverage solely because the service is provided through telehealth services.

(d) The plan shall provide reimbursement for a telehealth service at a rate negotiated between the provider and the insurance company.

(e) 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 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 the plan 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.



WISCONSIN



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

Wisconsin

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

Wyoming

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

For more information about specific state Telehealth Commercial Payer Statutes, please contact your Foley attorney or any of the following members of the Telemedicine and Digital Health Industry Team.



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