TELEHEALTH: CONSENT, LICENSURE, LAWS AND LIABILITY

CONSENT:

- WV requires **written OR verbal consent** prior to telehealth visits and this consent must be documented in the record. Written consent can be done yearly as part of general consent to provide services. https://www.cchpca.org/policy-101/?category=informed-consent
- WV Medicaid currently requires **WRITTEN consent** for Telehealth services as per **519.17 Telehealth Services in the WV HHR BMS Provider Manual** as of Jan 1, 2022.

- **From MEDICAID WV Policy Manual Jan 1, 2022:** Visit Document must include: WRITTEN Consent to receive treatment (may be included in the member's initial general consent for treatment) and must include: the right to withdraw, description of the risks, benefits and consequences of telemedicine, application of all existing confidentiality protections, right of the patient to documentation regarding all transmitted medical information, prohibition of dissemination of any patient images or information to other entities without further written consent.
  - Generally, consent must consist of 4 components:
    1. Acknowledgement that telehealth cannot provide the same evaluation as an in-person visit
    2. Make patient aware that details of visit/medical issues may require that patient come into the office or ER/urgent care to be evaluated in person
    3. Inform patient the visit is encrypted and secure, but nothing is 100%
    4. Be sure patient understands their consent can be revoked at any time.
    5. Consent of patient to include any others present for the visit.

Example of simple documentation of verbal consent:

VERBAL CONSENT

Date: _____ Patient Name: _____ DOB: _____

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

Example of More Complex Consent: National Consortium Telehealth Resource Center https://3f9znz109u3oybcpa3vow591-wpengine.netdna-ssl.com/wp-content/uploads/2021/11/Sample_Informed_Consent_for_Telehealth_Consultations.pdf

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LICENSURE:

ALTHOUGH THERE ARE FEDERAL GUIDELINES, LICENSURE IS PRIMARILY A **STATE CONTROLLED ISSUE**. THE **STATE WHERE THE PATIENT IS PHYSICALLY LOCATED AT THE TIME OF THE VISIT** GENERALLY DETERMINES THE LICENSURE LAW. INSURERS may also mandate licensure in the state where patient is located at time of service.

FEDERAL: MEDICARE AND MEDICAID:

- **BEFORE COVID 19:** Generally, providers must be licensed in the state which relates to their Medicare enrollment and where the patient is located at the time of the visit.
- **DURING COVID-19 Emergency Waiver:** There is temporary relaxation of requirement to be licensed in the state where patient is physically present (not where they reside). The provider must have a valid license in the state which relates to their Medicare enrollment, in furnishing services in the state

where emergency is occurring and not excluded from practicing in that state or any other state that is part of the emergency. **State requirements still apply. It is important to check the state legislature or licensing board of the state where patient is located to determine rules.**

- **Public Readiness and Emergency Preparedness Act (PReP Act)** : *(From CCHP, Center for Connected Health Policy*)
  On Dec 3, 2020, HHS secretary amended the act a fourth time by creating a declaration to provide immunity from liability in certain circumstances. This declaration "allows healthcare personnel who are permitted to order and administer a ***Covered Countermeasure through telehealth*** in a state to do so for patients in another state so long as the healthcare personnel complies with the legal requirements of the state in which they are licensed or permitted to practice. Any state laws that prohibit the qualified person from ordering and administering the covered countermeasures through telehealth is preempted, including licensing laws. It is important to note that this exception from licensure, and immunity protection is ***extremely limited***. It applies only to healthcare personnel ordering or administering the covered countermeasures described below. It does **NOT** apply to all types of healthcare providers or services. A Covered Countermeasure as in this act is defined as:
    - A qualified pandemic or epidemic product
    - A security countermeasure
    - A drug, biological product, or device that is authorized for emergency use, or
    - A respiratory protective device that is approved by the National institute for occupational safety and health
- **POST COVID:** Licensure will revert to PRE COVID law meaning providers must be licensed in the state which relates to their CMS enrollment and where the patient is located at the time of the visit unless state law allows otherwise.

<u>WV LAWS AFFECTING TELEHEALTH LICENSURE</u>:
BEFORE COVID 19: From WV Legislature CODE: All providers require active licensure in the state of WV if treating patient located in WV at the time of visit. **Interstate Medical Licensure Compact (IMLC):** WV does participate as a **State of Principal Licensure (SPL)** in the IMLC thus allowing members expedited pathway for licensure in WV and for those from WV to be licensed similarly in multiple other participating states. This is separate licensing process from the usual medical license in WVBOM. NOTE: All states surrounding WV do not fully participate yet
DURING COVID 19 PHE:

- **Governor Emergency Authorization: March 16, 2020**:
  https://governor.wv.gov/Documents/2020%20Proclamations/State-of-Emergency-March-16-2020.pdf
    - **WV BOM (M.D.s, PAs)**: Due to the State of Emergency declared by the Governor, physicians and/or physician assistants licensed in another state or **who are inactive or retired from West Virginia practice may provide medical care in West Virginia under special provisions during the period of the declared emergency**, subject to such limitations and conditions as the Governor may prescribe. Registrants may practice medicine in West Virginia consistent with their scope of practice and the standard of care and may practice in person or via telemedicine technologies to West Virginia patients. To register, out of state physicians and physician assistants:
        - must hold a valid, permanent, current, and unrestricted license to practice in another state.
        - must not be the subject of a pending or active complaint, investigation, Consent Order, Board Order or pending disciplinary proceeding in any jurisdiction; and
        - must not have not surrendered a license while under investigation or had a license revoked in any jurisdiction.
    - **WV Board of Osteopathy (D.O.s)**: To maximize the number of healthcare providers available during the State of Emergency declared by Governor Jim Justice regarding the COVID-19 pandemic, the Board has developed procedures for **emergency temporary permits** for the following practitioners:

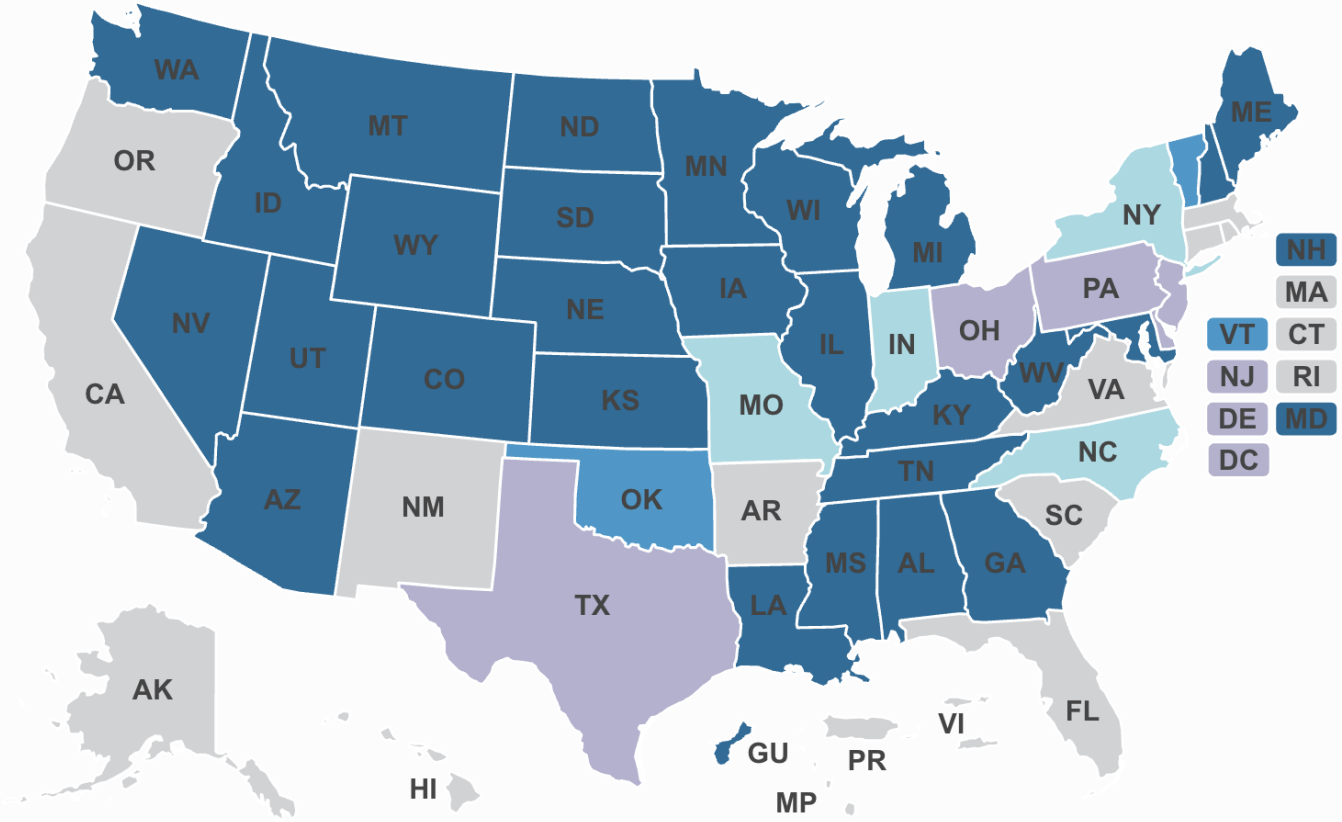
- Out-of-State Practitioners: DOs and PAs who have no pending complaints, investigations, consent orders, board orders, or pending disciplinary proceedings and who possess valid, unrestricted medical licensure in another state, district, or territory of the United States…
- Individuals seeking an emergency temporary permit may not begin practicing in West Virginia until they have received authorization from the Board.
- Individuals obtaining an emergency temporary permit shall be subject to the Board's jurisdiction…
- Emergency Temporary Permits will remain valid until terminated by the Board or the State of Emergency is lifted, whichever occurs first.
- Re: renewals - The extended deadline for licensure renewals, brought about by the COVID-19 pandemic, expired September 30, 2020. Under normal circumstances, the renewal period, which began online May 11, 2020 would have concluded on June 30, 2020…
- Status – Active until the end of the COVID-19 emergency

DURING AND AFTER THE PHE:

- **HB2024 *PASSED*** Emergency Rule for Interstate Telehealth Services: (Effective from passage March 30, 2021) WV 30-1-26 (Permanent) http://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=HB2024%20SUB%20ENR.htm&yr=2021&sesstype=RS&billtype=B&houseorig=H&i=2024
  - Established ability of providers outside the state of WV to care for patients in WV during emergencies through special registration
  - Providers must be in good standing and without current investigation in their home state.
  - Must provide care in their scope of practice.
  - Must register with the appropriate licensing board in WV and pay a fee. Board may impose discipline. Board of Medicine/Board of Osteopathy to administer registration.
  - May provide care by synchronous or asynchronous Audio only or Audio Visual, Remote Patient Monitoring. Does not include email, fax or questionnaires.
  - There must be an IN PERSON visit to a provider within 12 months prior to telehealth encounter. Exceptions:
    - post op follow-up
    - acute in-patient telehealth consultations
    - behavioral health telehealth
    - addition medicine telehealth
    - palliative care
    - and case by case rule by the provider involved if documented.
  - Can't perform these visits from within a location in WV without a WV license.
  - **Can't prescribe Schedule II medications** unless allowed by another section. This does not apply to a physician or a member of the same group practice of the established patient (who has met Schedule II requirements).
- **Interstate Medical Licensure Compact (IMLC):** https://www.imlcc.org/

WV continues to participate as a **State of Principal Licensure (SPL)** in the IMLC thus allowing members expedited pathway for licensure in WV and for those from WV to be licensed similarly in multiple other participating states. This is separate licensing process from the usual medical license in WVBOM. NOTE: All states surrounding WV do not fully participate yet.

U.S. State Participation in the Compact



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

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

SPL: State of Principal Licensure

WHAT HAPPENS WHEN THE PATIENT IS AT HOME OR TRAVELING IN A BORDERING STATE?

VIRGINIA LAW: From Virginia Legislature Code: Guidance document: 85-12 Revised: June 24, 2021 Effective: August 19, 2021 https://www.dhp.virginia.gov/media/dhpweb/docs/med/guidance/85-12.pdf
Summary: Provider must be licensed in the state where provider is located and where the patient is located except consultation of one provider with another provider who is licensed in state where patient is located and involved in their care.

Licensure: The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

Section Five: Electronic Medical Services That Do Not Require Licensure.

The Code of Virginia has two sections of law that are pertinent to telemedicine and the requirement of a Virginia license to provide services to a patient residing in the Commonwealth. The first is the "consultant exemption" found in § 54.1-2901 which lists Exceptions and Exemptions Generally to licensure. Subsection (A)(15) reads as follows: "Any legally qualified out-of-state or foreign practitioner from meeting in consultation with legally licensed practitioners in this Commonwealth." This statute is intended to have a Virginia practitioner involved in the care of the patient when a practitioner in another state/country consults with the Virginia practitioner or the patient. It provides an opportunity for Virginia residents to benefit from the expertise of practitioners known for specializing in certain conditions. There must be regular communication between the consultant and the Virginia practitioner while the consultation/care is being provided. The second section of the Code of Virginia pertinent to telemedicine is § 38.2-3418.16 of the Code of Virginia, which provides the definition of telemedicine in the Insurance Title. The section enumerates what does and what does not constitute telemedicine. Section 38.2-3418.16 defines telemedicine as "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." To practice telemedicine inVirginia requires a license from the Board of Medicine. The Board notes that § 38.2-3418.16 states "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire. The Board believes that these communications do not constitute telemedicine, and therefore do not require licensure, when used in the follow-up care of a Virginia resident with whom a bona fide practitioner-patient relationship has been previously established. The establishment of a new practitioner-patient relationship requires a Virginia license and must comport with the requirements for telemedicine found in § 54.1-3303 of the Code of Virginia.

PENNSYLVANIA:

From CCHP and: PA Statutes Annotated, Title 63 Sec. 422.34(a) and (c)(2). (Accessed Oct. 2021).

Summary: Allowed in bordering counties based on Provider characteristics and availability of medical care in area. License must be granted by Pennsylvania.

Pennsylvania issues extraterritorial licenses that allow practice in Pennsylvania to physicians residing or practicing with unrestricted licenses in an adjoining state, near the Pennsylvania boundary, and whose practice extends into Pennsylvania.

Pennsylvania bases the granting of this license on the availability of medical care in the area involved, and whether the adjoining state extends similar privileges to Pennsylvania physicians.

KENTUCKY:

From CCHP and SOURCE: KY Revised Statutes § 311.560. (Accessed Sept. 2021).

Summary: Consultation only and with a KY provider involved.

A provider must be licensed in Kentucky with the exception of persons who, being nonresidents of Kentucky and lawfully licensed to practice medicine or osteopathy in their states of actual residence, infrequently engage in the practice of medicine or osteopathy within this state, when called to see or attend particular patients in consultation and association with a Kentucky-licensed physician.

OHIO:

Unknown at this time. Please contact OHIO state legislature and Respective Medical Boards

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TELEHEALTH LAW:

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

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

TIMELINE OF FEDERAL LAWS AFFECTING TELEHEALTH : From CMS website.

- **WAIVER 1135**: Jan 31, 2020: HHS Secretary declared a **Public Health Emergency (PHE)** on Jan 31, 2020 and will remain in effect until the end of the emergency is declared. **Renewed to April 17, 2022 as of the writing of this document.**
- March 1, 2020: RHC and FQHCs **Audio-only telehealth services allowed**. SEE CMS website for codes billable with Audio-only vs those requiring Audio-visual component.
- March 6, 2020: HHS **expanded number of codes billable by telehealth**. HHS stated they would not perform audits to determine if telehealth patient was "established" or not.
- March 6, 2020: **RHCs and FQHCs can act as distant site** with provider at home or at clinic. Patient can be at home.

- **CARES ACT *PASSED***: **HR 6074: SIGNED March 17, 2020**: **Waived the previous requirements for originating and distant sites for telehealth.**
    a. Allowed telehealth for New patients during the PHE (not permanent)
    b. Removed policy on facility fees. Facility fees defined in COVID 19 policy
    c. Removed the requirement of Audio-visual and allowing just audio for visits with some codes
    d. FQHCs and RHCs can act as distant sites during the PHE (not permanent). Costs for telehealth visits will not be used to determine the payment amount for PPS/AIR
    e. Secretary of HHS now able waive monthly face-to-face requirement for dialysis patients, and for re certification of hospice patients, and home health services during the PHE (NOT PERMANENT)
- March 19, 2020: **CMS issues guidance on HIPAA and Telehealth**
    a. OCR will exercise enforcement discretion and will not impose penalties for noncompliance with HIPAA Rules in connection with the good faith provision of telehealth during the COVID -10 PHE.
    b. Provider can use audio or video communication technology to provide telehealth as long as non-public facing. For example, cannot use Facebook Live, Twitch, TikTok etc.
    c. Use of vendors that are HIPAA compliant and will enter into Business Associate Agreements (BAAs) are preferable.
- March 29, 2020: HR 748: **Expanded list of eligible providers** and Interim Rule from CMS
- March 30, 2020: CMS **expands list of eligible telehealth codes** by adding 80 more codes. Total of 280.
- April 7, 2020: First CMS **Guidance for FQHCs/RHCs** issued.
    a. Supervision can be virtual via Audio Visual.
    b. RHC and FQHC can be distant sites.
    c. COVID 19 specimen collection is not separately reimbursable in RHC and FQHCs.
    d. RHC and FQHC can bill G2025 for any telehealth code allowable by Medicare.
    e. To bill Audio only: Must be more than 5 min of time and NOT originating from a visit within the last 7 days or lead to an E and M service in the next 24 hours (or next available).
    f. Allowed for E Visits using code G0071

- May 27, 2020: **Updated CMS Guidance for FQHCs/RHCs** issued
    a. RHC to report originating and distant site cost on CMS 222-17 on Line 79 of Worksheet A as "Cost other than RHC services".
    b. FQHC to report originating and distant site cost on CMS 224-14 on Line 66 of Worksheet A as "Other FQHC services".
- April 8, 2021:
    a. CMS **expands eligible providers to all those eligible to bill Medicare** for their professional services, including OT, PT, Speech therapists. Can also bill "Incident to" telehealth for some other providers such as respiratory techs.
    b. **Allows audio only for certain services previously requiring Video component**, particularly, behavioral health, medical nutritional therapy, speech therapy, physical therapy, speech therapy codes.

PERMANENT TELEHEALTH LAW:

CONSOLIDATED APPROPRIATIONS ACT OF 2021, *PASSED*: **SIGNED Dec 27, 2020.** This 5000+ page bill contained several sections relevant to telehealth.
https://www.congress.gov/bill/116th-congress/house-bill/133/text

c. First: Addition of new payment designation of rural emergency hospital (REM) for facilities of 50 beds or less to the list of originating sites eligible for reimbursement (still needing to meet CMS telehealth definition of 'Rural" with HRSA qualifications and must be eligible provider and services).
d. Second: **Exemption from Medicare's rural geographic requirement** for eligible telehealth including audio only for individuals for purposes of diagnosis, evaluation, and management of a **mental health disorder** once the COVID 19 emergency ends. (The same exemption already exists for treatment of substance use disorder.) **One caveat: Provider must have had at least one in-person visit with patient within the prior 6 months. A 12 month in-person requirement thereafter with each subsequent mental health telehealth visit.**
e. Third: **Maternal, Infant and Early Childhood Home Visit Program**, during COVID 19 emergency, a **virtual home visit** can be considered a home visit.
f. **Significant funding** is dedicated to assessment and mitigation of the **broadband "digital divide"** to improve access to those in rural and remote areas.

CONSOLIDATED APPROPRIATIONS ACT OF 2022: PASSED: SIGNED March 15, 2022: From CCHP newsletter March 2022.

- **Telehealth Flexibility Location –** Geographic & rural exceptions to allow for any site including the home to continue for 151 days after the PHE ends – no facility fee for these sites
- **Telehealth Flexibility Provider Type** – Adds occupational therapists, physical therapists, speech-language pathologists, audiologists, and federally qualified health centers (FQHCs) and rural health clinics (RHCs) to eligible provider list for 151 days
- **Audio-Only** – Continue to allow for the 151-day extension period
- **In-person visit requirement for telemental health** – Delay requirement until after the 151 days extension
- **Use of telehealth for recertification of eligibility for hospice care –** Continue to allow for the 151-day extension period
- **New Reports**
    - MedPAC report due June 15, 2023 to Congress, includes looking at payment policy for telehealth for FQHC and RHCs

- Beginning July 1, 2022, Secretary of Health and Human Services must publicly publish on quarterly basis data on Medicare claims on telehealth services including utilization and beneficiary characteristics
- By June, 15, 2023, Office of Inspector General to submit to Congress fraud, waste, and abuse report on program integrity

MAJOR PENDING OR INTRODUCED TELEHEALTH LAW

THE TELEHEALTH MODERNIZATION ACT of 2020: **PENDING**: Bipartisan legislation introduced in both House and Senate to make the expanded access to telehealth services permanent. This law would lift the rural-only restriction and add any site where a patient is located as a potential originating site. This would ensure all Medicare beneficiaries may receive covered Medicare telehealth benefit, including at home and via mobile technologies as appropriate.

CONNECT for HEALTH ACT of 2021: SB 1512 PENDING. Designed to remove barriers to telehealth coverage, establish program integrity and evaluate data and testing of models. There are many areas of telehealth affected by this bill.

- **DEFINITIONS**:
  - **"telecommunications system"**: Current law requires telehealth to occur via an interactive telecommunications system. CMS has interpreted that to be synchronous audio-video and needs congress to redefine this in order to permanently allow audio only telehealth visits. This bill proposes that the HHS Secretary be allowed to "modify the definition when appropriate". It is the intent of congress that audio only telehealth be allowed permanently.
- **LOCATION OF PATIENT**:
  - Geographic Limitations will be removed.
  - Home will be allowed as originating site for all services
  - HHS Secretary may allow additional sites and develop rules and policy for those sites
  - Geographic limitations will not apply to Indian Health Service (HIS) Facility
  - Geographic limitations will not apply if providing emergency care
  - There will be no facility fees for some of these new locations such as home
- **PROVIDERS:**
  - RHCs and FQHCs will be able to act as distant sites (permanently)
  - RHCs and FQHCs will receive their prospective payment service rate instead of the G2025 rate as in the PHE.
- **SERVICES COVERED**:
  - HHS Secretary will have ability to temporarily add services to the list eligible for telehealth
- **ADDITIONAL ITEMS**: HHS Secretary shall have the ability to waive
  - Originating site limitations
  - Geographic limitations
  - Limits on types of technology used
  - Eligible providers for CMS telehealth services
  - Types of CMS Services covered by telehealth

- Any other limitation HHS Secretary deems necessary

THE PROTECTING RURAL TELEHEALTH ACCESS, **SB1988: (*Introduced 6/9/2021*).** From CONGRESS.GOV
Manchin, Joe (D-WVa), Cosponsors: Ernst, Joni (R-Iowa), Shaheen, Jeanne (D-NH), Moran, Jerry(R-KS), Sinema, Kyrsten(D-AZ), Cramer, Kevin(R-ND), Boozman, John(R-AR), Tester, Jon(D-MT), Capito, Shelley Moore(R-WV), Lummis, CynthiaM.(R-WY), Grassley, Chuck(R-IA), Rosen, Jacky(D-NV).

- **SUMMARY:** This bill expands coverage of telehealth services under Medicare. Specifically, the bill permanently: (1) removes geographic restrictions on originating sites (i.e., the location of the beneficiary), (2) allows the home of the beneficiary to serve as the originating site for all services, (3) allows federally qualified health centers and rural health clinics to serve as the distant site (i.e., the location of the health care practitioner), and (4) expands coverage to include audio-only services for evaluation and management and behavioral health services.

THE TELEHEALTH EXTENSION AND EVALUATION ACT: SB 3593 (Sen.Young R-IN) *(Introduced 2/08/2022) From CCHP March 8, 2022 Newsletter.*

This bill proposes the following:

- 2year extension of telehealth services beginning upon expiration of the COVID 19 PHE.
- During that 2year extension the bill would ensure:
  - Payment of telehealth services in Medicare for FQHC/RHC's as distant sites at full PPE rates
  - Ensure payment of telehealth services via telecommunications systems by critical access hospitals
  - Allow prescribing of controlled substances by providers at a different location than patient via a synchronous audio-visual system
- Reports: within the first year, the Secretary of HHS would be required to conduct and complete a report studying the effects of the telehealth changes under Medicare and Medicaid programs since the beginning of the COVID-19 emergency.

What DID CMS do permanently as of Jan 2022?

FROM: CCHP NEWSLETTER Dec 2021: Leadership looks back on Telehealth Policy 2021 from The National Telehealth Policy Resource Center

As of Dec 2021, CMS added the following services:

- "Category 3": CMS added many of the codes expanded to include telehealth during the pandemic, but not all to Category 3 which allows coverage until the end of 2023 such that they can be studied further and evaluated for permanency.
- Audio only or Audio/Visual for mental health evaluation and management via telehealth without geographic restriction but with other in-person stipulations. Patients with SUD continue to have this ability without in-person limitations.
- FQHC/RHC can be distant site providers for mental health evaluation and management including Audio only when patient is unable or chooses not to do Audio Visual. (CMS did this by redefining mental health visit for FQHC/RHCs therefore sidestepping Congress. CMS DOES NOT CONSIDER THIS TELEHEALTH)
- Remote Therapeutic Monitoring and Remote Physiologic Monitoring will be covered services.
- Medical nutritional therapy and diabetes self-management training services may be provided as telehealth when provided by a registered dietician or nutritional professional as distant site provider.

WV STATE TELEHEALTH LAW:

Note: These laws govern mostly Medicaid, PEIA and commercial insurers.

WV Governor Emergency Authorization: March 16, 2020

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

Medicaid: Moved to **permanently** allow Clinical psychologists and Psychiatrists at FQHCs and RHCs to act as a DISTANT site.

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

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

WV HB2024 (Effective from passage March 30, 2021)
http://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=HB2024%20SUB%20ENR.htm&yr=2021&sesstype=RS&billtype=B&houseorig=H&i=2024

- Medicaid:
  - The Medicaid plan, which issues, renews, amends, or adjusts a plan, policy, contract, or agreement on or after July 1, 2021, shall provide reimbursement for a telehealth service at a rate negotiated between the provider and the insurance company for virtual telehealth encounters. "Virtual telehealth" means a new patient or follow-up patient for acute care that does not require chronic management or scheduled medications.
  - The Medicaid plan, which issues, renews, amends, or adjusts a plan, policy, contract, or agreement on or after July 1, 2021, shall provide reimbursement for a telehealth service for an established patient, or care rendered on a consulting basis to a patient located in an acute care facility whether inpatient or outpatient on the same basis and at the same rate under a contract, plan, agreement, or policy as if the service is provided through an in-person encounter rather than provided via telehealth.
  - Medicaid Rule: Remote Patient Monitoring and Store and Forward is not covered.
  - Medicaid rule change (not HB2404) FQHC/RHC: can act as an originating site as before PHE. Allowed to be distant site for psychologist and psychiatrists **only** via Audio only or Audio-visual but not not fax, text or email.

- Commercial and PEIA Insurance Coverage:
  - Plans must cover telehealth if same service covered for face-to-face visits.
  - Fees for "Virtual Telehealth" to be negotiated after July 1, 2021. "Virtual telehealth" means a new patient or follow-up patient for acute care that does not require chronic management or scheduled medications.
  - Fees for services are negotiated for face-to-face and will be reimbursed equally if provided by telehealth.
  - Plans cannot exclude a service just based on provision by telehealth.
  - Annual or lifetime limitations of benefits for telehealth services are prohibited.
  - Provider/hospital allowed to charge "originating site" fee if appropriate.
- Emergency Rule for Interstate Telehealth Services:
  - Established ability of providers outside the state of WV to care for patients in WV during emergencies through special registration
  - Providers must be in good standing and without current investigation in their home state.
  - Must provide care in their scope of practice.
  - Must register with the appropriate licensing board in WV and pay a fee.
  - May provide care by synchronous or asynchronous Audio only or Audio Visual, Remote Patient Monitoring. Does not include email, fax or questionnaires.
  - There must be an IN PERSON visit to a provider within 12 months prior to telehealth encounter. Exceptions: Case by case rule by practitioner, such as: post op follow-up, acute in-patient telehealth consultations, behavioral health telehealth, addiction medicine telehealth and palliative care.
  - Can't perform these visits from within a location in WV without a WV license.
- Prescribing Limitations
  - No prescribing of Schedule II drugs.
  - Any provider who sees a patient solely through telemedicine, cannot prescribe Schedule II to that patient. Exceptions: Minor (under 18) and those 18 and older in primary or secondary education with intellectual or developmental disabilities, neurological disease, ADHD, autism, traumatic brain injury.

- Requirements for Documentation
    - VERIFY identity and location of PATIENT.
    - PROVIDE identity, qualifications, location and contact information of the provider.
    - Provider must DETERMINE if telehealth is appropriate type of service for the patient's problem.
    - OBTAIN and DOCUMENT consent.
    - Provide evaluation and management as if patient was being seen in person.
    - Health record CONTENT should reflect all of the above
- In-Person Requirement:
    - Patient must have an in-person visit with a health care provider within 12 months prior to the telehealth visit to qualify for services.

TELEHEALTH LIABILITY:

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

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

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

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

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