

Staying Connected

A Progress Report: Reimbursement under the Telemedicine Development Act of 1996

I. Introduction

California has been a national leader in developing telehealth¹ technologies to improve health care access and quality, particularly for medically underserved populations. The University of California health system, other clinical centers of excellence, and inpatient and outpatient ambulatory care providers have explored ways to develop and sustain a broad range of telehealth programs to transform health care.² These and other organizations, committed to bridging the digital divide and addressing the growing disparities in access to health services in rural and underserved communities, along with funding by a number of California foundations, are key reasons that telemedicine has made significant progress in California.³

The California Telemedicine Development Act of 1996⁴ (TDA) was one of the nation's first state telemedicine statutes, and

Advances in technology have led to new models of patient-clinician interaction that weren't fully contemplated at the time the TDA was first enacted.

many other states have used it as a model. Since its passage, however, improvements in broadband availability and health-related hardware and software have made possible new models of remote consultation

among providers, transfer of medical images, and clinician-patient interaction not fully contemplated when the TDA was first enacted.

This policy brief focuses on implementation of the TDA provisions related to health plan, insurer, and Medi-Cal telemedicine coverage and payment policies. The goal of reviewing the TDA is to support California's continued leadership in telehealth

California's telemedicine coverage law was a groundbreaking statute at the time of its passage and became a model law for other states. This issue brief takes a look at implementation of the TDA provisions related to reimbursement policy.

While the TDA improved coverage of telemedicine in both public and private health care programs, it may not have accomplished all that proponents hoped for when they worked for its passage. The fast pace of changes in technology; the complexities of health care delivery, billing, and payment; and limitations of the statute all point to the need for a fresh look. An update of the TDA seems warranted if California is going to continue to lead the way in using telehealth technologies as tools to reshape health care into a more patient-centered and accountable system

and to ensure a strong and workable statutory framework for ongoing and emerging telemedicine. The findings in this brief are based on a review of public and private payment policies and coverage documents; interviews with stakeholders, including health plans, providers, and consumer advocates; and analysis of relevant articles and reports.

II. The TDA

The TDA, incorporating subsequent amendments to the original law, defines "telemedicine" as *the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications*. It defines "interactive" as *an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information*. The TDA specifically excludes telephone or e-mail contact between patient and provider from its definition.⁵ (The text of the TDA is included in the Appendix of this brief.)



Among other things, the TDA establishes telemedicine as a legitimate means of receiving health care services.⁶ The TDA requires the health care provider with ultimate authority for a patient to obtain patient informed consent for telemedicine, and to provide the patient with specific information about potential risks and benefits.

Legislative Intent

The original TDA legislation—SB 1665 (Thompson, M.) of 1996—expressed legislative findings and intent that telemedicine:

- Has the potential to reduce costs, improve quality, and improve access;
- Has been utilized in one form or another for more than 30 years;
- Will assist in maintaining or improving the physical and economic health of underserved communities by keeping the source of medical care in local areas and preserving health care-related jobs;
- Benefits consumers with expanded access to providers, faster and more convenient treatment, better continuity of care, reduction of lost work time and travel costs;
- Does not change the existing scope of practice of any licensed health professional; and,
- Does not replace health care providers, but preserves and enhances the provider-patient relationship.

The TDA prohibits health plans and health insurers,⁷ as well as Medi-Cal, from requiring face-to-face contact between a patient and a provider for services appropriately provided through telemedicine, subject to all other contract or policy terms.⁸ The TDA also states that health plans are not required to reimburse for consultations provided via phone or fax. The TDA specifically requires Medi-Cal to cover teleophthalmology and teledermatology services via store-and-forward technology, as defined by the TDA.⁹

According to legislative committee analyses of the original bill, proponents supported the TDA with the expectation that health plans would be required to develop telemedicine reimbursement policies. However, the TDA simply requires health plans and insurers to apply internal claims payment and appeal standards to telemedicine. As one committee analysis stated, the TDA “attempts to encourage health insurers to develop telemedicine policies.”¹⁰

III. TDA Implementation Findings

Enactment of the TDA relatively early in the evolution of telemedicine established California as a national policy leader. Though telemedicine has been available for years—and despite its success in rural pockets of California—its use throughout the state is not widespread. Interviewees for this study identified multiple barriers to expansion of telemedi-

Legislative History of the TDA

1996	SB 1665 (Thompson, M.), Chapter 864, Statutes of 1996, the Telemedicine Development Act of 1996, prohibits health plans, health insurers, and the Medi-Cal program from requiring face-to-face interactions between patients and providers for services appropriately provided by telemedicine.
1997	SB 922 (Thompson, M.), Chapter 199, Statutes of 1997, excludes telephone conversations and electronic mail messages between a health care practitioner and a patient from the definition of telemedicine in the TDA.
2003	AB 116 (Nakano), Chapter 20, Statutes of 2003, applies the informed consent provisions of the TDA to dentists, podiatrists, psychologists, marriage and family therapists, and clinical social workers.
2005	AB 354 (Cogdill), Chapter 449, Statutes of 2005, prohibits, from July 2006 through December 2008, the requirement of face-to-face contact between a health care provider and a patient for Medi-Cal store-and-forward teleophthalmology and teledermatology services.
2008	AB 2120 (Galgiani) extends the TDA teleophthalmology and teledermatology store-and-forward requirements for Medi-Cal until January 1, 2013.
2009	AB 175 (Galgiani), Chapter 419, Statutes of 2009, includes within the definition of teleophthalmology and teledermatology store-and-forward consultations provided by optometrists.

What are Telehealth and Telemedicine?

Telehealth is the use of telecommunications technology to deliver medical care, health education, and public health services. Telehealth encompasses a broad definition of technology-enabled health care services, all of which connect multiple users in separate locations. This definition encompasses **telemedicine**, a term that describes the diagnosis and direct treatment of illness. Telehealth services consist of diagnosis, treatment, assessment, monitoring, communications, and education.

Telehealth services are delivered in three main ways:

- Video conferencing, used for real-time patient exams, provider-patient consults, and provider-to-provider discussions;
- Patient monitoring, in which electronic measurement devices connect patients with health care providers; and,
- Store-and-forward technologies, a term for the electronic transmission of digital images, such as X-rays and photos, between primary care providers and medical specialists.

ciné: overall low reimbursement levels in health care; limited provider knowledge on how to deliver and bill for telemedicine; restrictions on the sites, providers, and services that will be paid for when provided via telemedicine; and reluctance among many health plans, medical groups, and providers to invest in the infrastructure needed for telemedicine.

The TDA has improved the chance for reimbursement and coverage of telemedicine in both public and private health care programs, but implementation has been uneven. This section highlights how the TDA has affected reimbursement for telemedicine in California.

- **The TDA is not as comprehensive as many proponents anticipated.** The TDA established a somewhat indirect mandate for coverage by prohibiting a requirement of **The TDA prohibits a face-to-face requirement but permits health plans to set the terms of coverage.** face-to-face contact for reimbursement. There is little evidence of health plans or insurers violating this face-to-face prohibition. The TDA does not, however, direct health plans or insurers to cover specific telemedicine applications

or to adopt specific telemedicine reimbursement policies. In addition, it fails to define what constitutes services “appropriately provided by telemedicine.”

- **Services provided via telemedicine are being reimbursed, but often providers must pursue appeals or educate payers.** There is some difference of opinion as to whether health plans and insurers are consistently reimbursing for telemedicine under the TDA. Early telemedicine adopters invested significant time and resources working with all payers to clear up billing system glitches and confusing policies. Long-established telemedicine providers now report that reimbursement is common for those who know and follow the rules, but some providers and advocates contend that they continue to experience reimbursement denials and administrative barriers to payment for telemedicine.
- **Health plan benefit materials and coverage guidelines, though technically in compliance with the TDA, often are silent or vague regarding telemedicine.** Evidence of coverage (EOC) documents are the mandatory disclosure documents provided to purchasers and consumers of a health coverage contract or insurance policy. Most EOCs are silent on telemedicine and telemedicine coverage, and most exclude coverage for any services provided by phone, e-mail, or the Internet. Several national insurers doing business in California exclude telemedicine coverage entirely in company-wide guidelines, “except as required by state law or policy.” Generic and vague coverage policies complicate tracking of TDA compliance and effective enforcement of its requirements.
- **Inconsistent payer policies increase administrative costs for providers.** Payer policies related to telemedicine are often unclear, inconsistent, and complicated. In addition to the policies applicable to public programs, each private health plan must be approached individually to obtain coverage and billing requirements. Some plans cover both live, interactive and store-and-forward services, while some cover only live interactions. Some provide a facility fee to the originating site, while some do not. Some have no distinct billing

Vague disclosures and guidelines limit effective enforcement and tracking of TDA compliance.

or payment system for telemedicine. The wide variations complicate claims and payment processing for telemedicine providers, increasing the costs of participation.

- **Awareness of the TDA is limited.** Many health plans, providers, medical groups, and their representative organizations have limited knowledge of the TDA. While a few health plans have staff assigned to work on telemedicine for public programs, telemedicine coverage does not appear to have high visibility or be well understood beyond the providers and health plans that have been the most active in pioneering telemedicine programs.
- **Telemedicine is used most often by safety net providers in public programs.** Most telemedicine innovation and investment in California has focused on improving health care access and overcoming geographic barriers to care for safety net populations, predominantly through community clinics and hospitals in rural and remote areas. As a result, public payers dominate reimbursement for telemedicine.
- **Payment policies may not recognize that telemedicine can overcome multiple access challenges beyond geography.** Telemedicine can be used to alleviate cultural and linguistic barriers, specialty provider shortages, and poor health care literacy. As one example, submitting a diabetic patient's retinal scan from the primary care site to an ophthalmologist via store-and-forward technology improves the likelihood that the consult will occur. For patients with transportation and other socio-economic challenges in seeking follow-up care, the opportunity to receive a service on-site at the time of a primary care visit can improve outcomes. Yet many policies only cover telemedicine when it is used to address geographic isolation and distance.
- **Existing reimbursement methods limit data.** Most interviewees agree that telemedicine use is underreported. One of the few data sources available on telemedicine use is the Anthem Blue Cross (BC) Telemedicine Network, which receives self-reported usage and payer information from the presenting sites. Anthem estimates the data received may be underreported by as much as 25%. Health plans that pay for telemedicine without distinguishing it from in-person services help to integrate telemedicine into mainstream care delivery, but also generate no usage data.

When providers choose not to use telemedicine codes because of complexity or fears of delayed reimbursement, telemedicine services are not captured as such in the

Lack of consistency in reimbursement policies increases administrative costs.

database. Telemedicine programs funded via grants may not yield encounter or service data. These data challenges

complicate monitoring, analysis of costs and benefits, and data-driven policy and business decisions.

- **The TDA and current reimbursement practices may be too restrictive to promote telemedicine expansion.** In general, telemedicine is currently reimbursed for specific authorized services and providers, for specific types of patients (often limited to remote or rural communities), or for specific barriers to in-person care. At the same time, improvements in technology have made possible new models for clinician-clinician and clinician-patient interaction. Emerging technologies such as remote monitoring of intensive care units and home monitoring of patients have already radically changed care delivery. Restrictive or narrow public and private reimbursement policies may not keep up with proven innovations and care improvements as they develop.

IV. Telemedicine Reimbursement Policies and the TDA

As background for considering the impact of the TDA on reimbursement for telemedicine, this section provides a general overview of public and private telemedicine payment policies in California.

Private Coverage for Telemedicine

Under the TDA, California health plans and insurers cannot require face-to-face contact between patients and providers, and there is little evidence of direct violation of this prohibition. Initially, many commercial plans would not reimburse for telemedicine at all despite TDA provisions,

but in the current environment many of those interviewed reported that if a provider knows how to bill and submit claims, most health plans do reimburse for services provided via telemedicine. For example, of services provided in the Anthem BC network in 2008–09, some 7% were paid for by private insurance.

Still, many contend that it remains difficult to get commercial health plan reimbursement for telemedicine in California, even in plans that otherwise have embraced telemedicine as part of their participation in public health care programs.

Telemedicine Coverage Laws in Other States

Ten other states have some form of health insurance coverage mandate for telemedicine. Five states (CO, HI, KY, OK, and TX) have adopted telemedicine statutes similar to California's that in some way prohibit the requirement of face-to-face contact for telemedicine reimbursement. Colorado only imposes the face-to-face prohibition in counties with 150,000 or fewer residents. Texas prohibits any exclusion from coverage of telemedicine solely because services were provided by telemedicine rather than face-to-face contact. Five states (GA, LA, ME, NH, and OR) have stronger requirements than California, including three states (LA, NH, and OR) that mandate coverage for telemedicine for any service that would be covered in person.

Arizona and New Mexico authorize telemedicine as a means of providing health care services, and North Dakota permits coverage in the state worker's compensation program. New Mexico prohibits physicians from being disciplined for or discouraged from participating in telehealth.

Thirty-six states, including California, have adopted telemedicine statutes or policies for coverage of telemedicine in Medicaid, five other states are considering doing so, and Florida covers telemedicine under the terms of a federal Medicaid waiver.

Sources: Compendium of State Laws on Insurance Topics. National Association of Insurance Commissioners: 2009. State-by-State Breakdown. American Telemedicine Association: January 2010 (obtained online at www.americantelemed.org). Private Payer Reimbursement. Center for Telehealth and E-Health Law: January 2010 (obtained online at www.telehealthlawcenter.org). Medicaid Reimbursement. Center for Telehealth and E-Health Law: December 2009 (obtained online at www.telehealthlawcenter.org).

Providers and advocates express continued frustration that coverage for telemedicine has been slow to develop in commercial health plans compared to public programs such as Medi-Cal. A few providers indicated that telemedicine claims submitted to commercial health plans are still denied, including instances where the denial states that telemedicine is not a covered benefit. Providers report that most health plans do not have clear reimbursement policies, billing codes, or guidelines for services provided via telemedicine. Interviewees reported that telemedicine is neither well understood by nor familiar to most commercial payers; many health plans and medical groups have failed to implement billing and payment system changes to facilitate prompt and easy reimbursement for telemedicine.

Health plan representatives point out that it is sometimes difficult to extend the use of telemedicine to commercially insured members. According to one large health plan, community clinics and health centers serving as telemedicine sites are often reluctant or unprepared to serve large numbers of commercial patients. In addition, plan representatives say that physicians who have successful and busy practices serving commercially insured patients may not feel the need

Advocates express frustration that telemedicine coverage has been slower to develop in commercial health plans than in public programs.

to expand their services to include telemedicine. Many physicians and some large medical groups, plan representatives say, remain unwilling to embrace telemedicine as a delivery method, or to invest in the systems and equipment necessary to implement the technology. One plan medical director said there is still a demand gap for telemedicine, stating that consumers do not yet expect regular access to telemedicine and are not always aware of telemedicine technologies.

Health plan representatives report that the lack of plan-level information about telemedicine is partly because of California's delegated model, in which many health plans contract with large, multi-specialty medical groups or independent practice associations (IPAs) for a fixed monthly fee per enrollee, leaving many policy, payment, and service delivery decisions to the delegated groups. Also, most of the state's very large health plans have limited numbers of enrollees

in the rural and underserved communities where telemedicine has been most prominent, so they have not prioritized development of telemedicine for the more urban populations enrolled in commercial coverage.

Telemedicine Guidelines and Policies

Two types of health plan documents were reviewed for this study in order to identify payment and coverage policies for telemedicine: evidence of coverage documents (EOCs) and internal health plan coverage and reimbursement guidelines. EOCs must meet specific statutory requirements and provide information to plan members about benefits, exclusions, and conditions of coverage. Internal health plan guidelines generally are not made publicly available but are developed to inform health plan staff and providers about billing and payment practices and are reviewed by regulators to verify that the health plan has taken steps to comply with state and federal laws.

EOCs are subject to review by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) for compliance with applicable state and federal laws, including the TDA. The policy forms and EOCs reviewed for this brief are in compliance with the TDA, in that there are no provisions requiring face-to-face contact between patients and providers. However, most disclosure documents say nothing at all about telemedicine. The majority of EOCs also specifically exclude coverage for services provided via e-mail, telephone, or the Internet, which could preclude coverage for some existing or emerging telemedicine applications.

Only a few of the largest health plans or insurers operating in the state have developed *California-specific* benefit or

Only a few large health plans have developed California-specific telemedicine reimbursement guidelines.

reimbursement guidelines for telemedicine, particularly for commercial health coverage products. Internal guidelines that do exist tend to be based primarily on Medicare billing and coding standards. Several

national health plans doing business in California rely on internal telemedicine payment guidelines that are not state specific and exclude coverage for telemedicine and/or telehealth “except as provided by state law.” One large health

plan reports it does not require providers to identify or code telemedicine any differently than the same services provided in person.

The internal coverage guideline of another large California-based health plan, which specifically references the TDA, identifies the following as “services appropriate by telemedicine” (including but not limited to):

- Cardiac telemetry remote interpretation transmitted through telemedicine;
- Remote interpretation of radiology images obtained through angiography; CT, MRI, and PET scanning; sonography; and thermography transmitted through telemedicine;
- Remote interpretation of pathology tissue specimen images transmitted through telemedicine; and,
- Diagnosis, interpretation, and treatment based on interactive audio/video transmission of a patient image.

Another national health plan’s internal guideline allows for variation by product and state but provides for coverage of medically necessary services via telemedicine, if not otherwise excluded in a particular plan, for individuals who live in geographically remote areas or who cannot access direct patient-provider health care, as follows:

- Specialist referrals/patient consultation (e.g., telephone, e-mail, or audio/video conferencing);
- Evaluation and monitoring services (e.g., electronic office visits, electronic hospital visits); and,
- Remote patient monitoring services when standard home health services are not available.

As permitted under the TDA, health plans and insurers often do impose terms and conditions for telemedicine coverage that may vary for specific plan types, such as preferred

Under the TDA, health plans and insurers can—and do—impose terms and conditions for the use of telemedicine.

provider organization (PPO) or health maintenance organization (HMO) plans. Among common requirements are that the service is medically necessary; that the service is for a benefit otherwise covered

under the contract or policy; or that the service cannot be provided in person for a demonstrated reason. One national insurer’s policy states that the use of telemedicine will not be

considered medically necessary solely for the convenience of the patient or the provider. As is generally the case for HMO services, telemedicine typically must be delivered by a provider participating in the health plan, and/or the referral must be made or approved by the patient's assigned IPA/medical group or primary care provider. Some health plans have eliminated specific prior authorization requirements for telemedicine, but some maintain them. Interviewees reported that contracted IPAs and medical groups are more likely than health plans to impose prior authorization requirements.

Although not required to do so under the TDA, neither DMHC nor CDI has developed an interpretive policy for enforcement purposes or as guidance to ensure compliance with the TDA. According to the DMHC, the TDA is clear on its face. As previously noted, current enforcement does not result in all health plans and insurers specifically addressing how they comply with the TDA in consumer disclosure documents. Statutory mandates on health plans and insurers are subject to enforcement primarily in response to consumer or provider complaints—and no TDA-related complaints have been received by the DMHC or CDI within the last three years.¹¹

DMHC reported it was not aware of any health plan proposing to meet existing access standards by using telemedicine, as permitted under the TDA. New timely access regulations for DMHC-regulated health plans took effect January 17, 2010.¹² These regulations require health plans to file an annual report by March 31, 2012, and by March 31 each year thereafter, showing timely access compliance. Among other things, the report must include a description of the implementation and use by the plan and its contracting providers of triage, *telemedicine*, and health information technology to meet the access-to-care standards.

California Public Employees Retirement System

The California Public Employees Retirement System (CalPERS) purchases health benefits for the State of California and more than 1,100 local government agencies and school employers, covering nearly 1.3 million active and retired public employees and their family members. CalPERS provides coverage through two private health plans and three self-funded plans.

On January 1, 2006, CalPERS initiated a telemedicine pilot program available to members enrolled in the self-funded PERS Select, PERS Choice, and PERSCare programs. Anthem BC administers the programs for a total of 228,000 enrollees, many of whom reside in rural areas. CalPERS covers live, interactive video and store-and-forward consultations in more than 18 primary and specialty care areas through the Anthem BC Telemedicine Network. As of the second quarter of 2009, according to CalPERS, 206 PERS Select/Choice/Care members had received telemedicine consultations. The top five consultations provided were in psychiatry, pediatric behavioral health, dermatology, endocrinology, and pediatric psychiatry.

Public Program Coverage for Telemedicine

Medicare

Medicare is the federal health insurance program that provides coverage for most people age 65 and older and younger people with disabilities or specific health conditions who meet eligibility criteria. Ten percent of the services provided through the Anthem BC Telemedicine Network in 2008–09 were paid for by Medicare.

The telemedicine benefit in Medicare is limited to services provided in rural and underserved areas; reimbursable services include, but are not limited to, consultation, office visits, individual psychotherapy, and pharmacy management.¹³ Telemedicine services may be provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, clinical psychologists, clinical social workers, and registered dietitians. Originating sites are limited to practitioner offices, hospitals, critical access hospitals, rural health clinics, federally qualified health centers, and (since January 2009) skilled nursing facilities, hospital-based dialysis centers, and community health centers. Medicare also pays a facility site fee for the originating site (\$23.72 in 2009). Store-and-forward services are not reimbursable under Medicare, except as part of a long-running pilot project in Alaska and Hawaii.

Federal proposals affecting telemedicine use in Medicare were introduced in 2009 and discussed as potential elements of federal health care reform. An amendment by Senator Tom Udall of New Mexico (Amendment 3136) focuses on high

impact, low cost strategic advances and high priorities for telemedicine. Among other things, the amendment would: 1) Direct the federal Centers for Medicare and Medicaid Services (CMS) to simplify credentialing and privileging of physicians and other providers and to cease enforcing existing restrictions; 2) Provide video conferencing coverage for the 34 million Medicare beneficiaries who live in metropolitan counties; and 3) Expand store-and-forward coverage beyond the Alaska and Hawaii pilot programs. Provisions offered by Congressman Mike Thompson (author of the TDA when a member of the California State Senate) would eliminate Medicare's geographic restrictions on reimbursement for telemedicine; expand coverage of telehealth services to home health services and remote patient monitoring; expand eligible health care providers to include all Medicare providers; and provide \$30 million in grants for telehealth services and programs.¹⁴

Medi-Cal

Administered by the Department of Health Care Services (DHCS), Medi-Cal is California's version of the federal Medicaid program, providing comprehensive health benefits to eligible low-income children and their parents or caretaker relatives; pregnant women; elderly, blind, or disabled persons; nursing home residents; and refugees. Nearly 60% of the telemedicine visits reported in the Anthem BC network in 2008–09 were paid for by Medi-Cal.

The federal Centers for Medicare and Medicaid Services (CMS) has not explicitly established a telemedicine benefit for Medicaid but has provided guidance to states that choose to cover telemedicine.¹⁵ CMS encourages states to “use the flexibility in federal law to create innovative payment methodologies for services that incorporate telemedicine technology.” CMS would allow reimbursing the provider at the hub site for the consultation and the provider at the spoke site for an office visit, along with reimbursing for additional costs such as technical support, transmission charges, and equipment. According to CMS, these costs can be incorporated into the fee-for-service rates or be billed separately as an administrative cost by the state, as long as the separately billed costs are linked to a covered Medicaid service. Limitations include Medicaid certification requirements for sites such as long-term care facilities and hospitals, which require that the physician be present in the same room as the patient during

Health Plan Telemedicine Investments

Some California health plans have made investments in telemedicine. The Anthem BC Telemedicine Network offers live video and store-and-forward consultations. The network uses an open “spider-web” approach, whereby any primary care location within the network can connect to any other primary care or specialty site. Anthem BC equips and trains rural clinical sites, provides reimbursement to them for telemedicine, and offers discounts for high-speed connections. Available to all patients regardless of payer source, the network today includes 66 presenting sites around the state, predominantly community clinics and rural and district hospitals, along with 15 centers providing consultations in more than 25 specialty areas. The network reported 5,138 clinical consultations from September 2008 through September 2009. The top six specialties have consistently been psychiatry, dermatology, endocrinology, optometry, pediatric neurology, and nutrition services.

UnitedHealth Group committed \$25 million for charitable contributions in California over four years as part of the regulatory approval for its 2005 merger with California-based PacifiCare Health Systems. United has awarded grants for technology, including telehealth-related improvements, to federally qualified health centers, rural health clinics, disproportionate share hospitals, critical access hospitals, school-based health centers, county health departments, migrant health centers, and other traditional safety net providers

the visit. Similarly, federal regulations require face-to-face, “hands-on” visits for home health, and telemedicine cannot be used as a substitute.

Medicaid programs vary from state to state, and within the state—in how they structure telemedicine coverage, what is covered (e.g., diagnosis, procedures), who can provide services (e.g., physicians or mid-level practitioners such as physician assistants), which site is reimbursed (hub or spoke), and whether the service must be live or can be via a store-and-forward consultation. Coding conventions for telemedicine billing and provider licensure issues also differ.¹⁶ States have been interested in reimbursement for telemedicine in Medicaid because of the promise of reduced transportation costs, improved access to services, and a potential for improvement in patient outcomes.¹⁷

California is one of 36 states with telemedicine policies for Medicaid, and in general Medi-Cal has one of the more comprehensive Medicaid telemedicine reimbursement policies among states.¹⁸ Medi-Cal coverage and billing standards for telemedicine are in compliance with the TDA.¹⁹ Unlike

California is one of 36 states with telemedicine policies for Medicaid.

underserved area—the presenting site is eligible for a billable visit as long as it meets the requirements of the Medi-Cal program. In late 2008, DHCS implemented a policy change to reimburse telemedicine originating sites with a flat rate facility fee for costs associated with coordinating and conducting telemedicine visits.

Medi-Cal does require that the telemedicine provider at the originating site document a barrier to receiving the service face to face. These examples are listed in the Medi-Cal telemedicine policy as potential barriers to be documented:

- Local provider unavailable;
- Local provider wait time unacceptable;

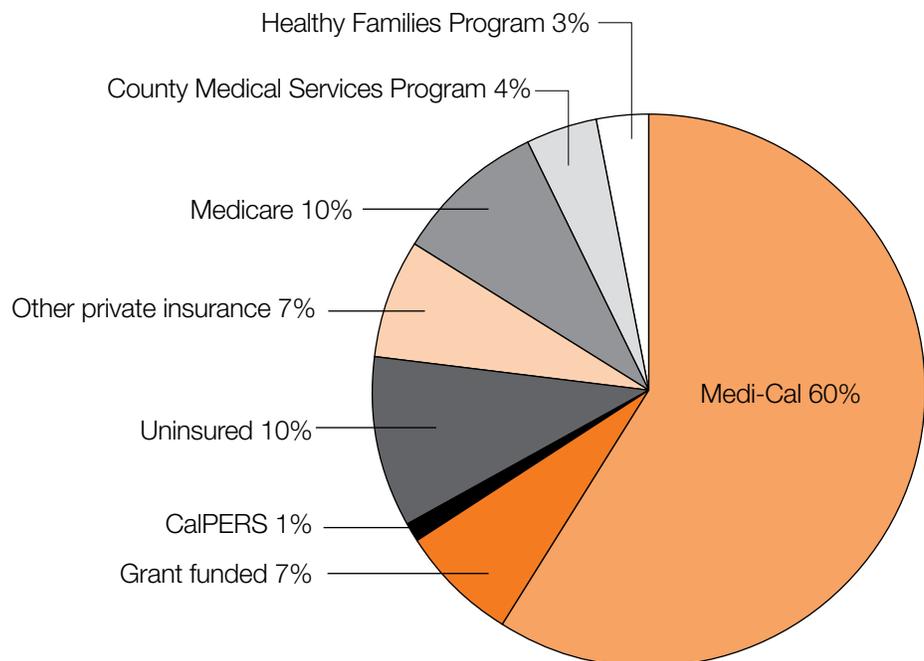
Medicare, for Medi-Cal there is no specific requirement that telemedicine be provided in a rural or

- Local provider unwilling to accept Medi-Cal;
- Local provider unable to address lingual or cultural needs of patient;
- Transportation unavailable; and,
- Time off work for travel creates a financial or personal hardship.

Like Medicare, Medi-Cal limits telemedicine coverage to practitioner offices, hospitals, critical access hospitals, rural health clinics, and federally qualified health centers, but Medi-Cal coverage has not yet expanded to the additional sites authorized by Medicare in 2009 (skilled nursing facilities, hospital-based dialysis centers, and community health centers). Medi-Cal also requires providers to use telemedicine claims modifiers, “GT” for live, interactive services and “GQ” for store-and-forward services. Medi-Cal covers telemedicine for a range of psychiatric services, outpatient and inpatient evaluation visits or consultations, X-ray and electrocardiogram interpretation, and teleophthalmology and teledermatology.

Figure 1: Telemedicine Consultations by Payer, Anthem BC Telemedicine Network, 2008–09

(As reported to Anthem BC by Network Sites) Percentages do not total 100% due to rounding to nearest whole percent.



Interviewees did express frustration with Medi-Cal telemedicine billing glitches in the early years following passage of the TDA. Several providers stopped using the telemedicine modifiers because the codes often resulted in denied or delayed claims. (DHCS acknowledges that some Medi-Cal services are likely being provided via telemedicine but not being billed as such.) Providers and advocates report that many of the initial Medi-Cal billing challenges have been resolved, including delays that often occurred because the documentation of barriers is submitted as an attachment to the claim and Medi-Cal claims reviewers were not always accessing the attachments. Most providers and advocates also point out that Medi-Cal reimbursement rates are extremely low and fail to cover provider overhead and costs. Health plans and providers agree that in order to make telemedicine more viable, providers need to be reimbursed by a mix of payers and not just Medi-Cal.

Medi-Cal Managed Care

As of this writing, approximately 3.8 million Medi-Cal beneficiaries receive care and services through one of 25 public or private managed care plans. The TDA provisions prohibiting face-to-face requirements do not apply to Medi-Cal managed care plans unless: 1) Medi-Cal provides coverage for telemedicine services; 2) Medi-Cal managed care rates are adjusted for telemedicine coverage; and, 3) Medi-Cal managed care contracts are amended to add telemedicine coverage.

The first condition has been met. According to DHCS, however, managed care contracts have not been amended to require telemedicine coverage, but Medi-Cal managed

Managed care plans reimburse for telemedicine for Medi-Cal members more often than for commercial members.

care rates do take into account payments for telemedicine made in the fee-for-service Medi-Cal program. Still, advocates and providers point out

that managed care plans typically reimburse for telemedicine to a much greater extent for Medi-Cal patients than for commercial patients.

County Mental Health Plans

In all but two counties, the county mental health department serves as the single managed health care plan for delivery and payment of Medi-Cal specialty mental health services under the terms of a federal Medicaid waiver. Such services are “carved out” of mainstream Medi-Cal managed care contracts. County mental health plans (MHPs) are not required to be licensed as health plans under California law but are subject to distinct requirements in their contracts with the state Department of Mental Health (DMH).

MHPs have been active users of telemedicine for mental health services, particularly in remote, rural communities. Telepsychiatry and telemental health services²⁰ are approved as reimbursable by both DHCS and DMH although usage is not reported on a statewide basis. According to the California Institute of Mental Health (CIMH),²¹ telemental health/telepsychiatry have consistently been among the most utilized services provided via telemedicine, due in part to the scarcity of mental health professionals in rural and underserved communities.²² In general, any medically necessary mental health services that otherwise meet coverage requirements are reimbursable by MHPs regardless of whether they are provided by phone, in the field, or in an office.

In 2002, CIMH and the California Mental Health Directors Association (CMHDA) worked with DMH and a coalition of telemedicine providers, trainers, and educators to develop an extensive telemedicine operations manual for MHPs.²³ The manual sets forth the minimum conditions for coverage of specialty mental health services via telemedicine, consistent with TDA requirements, and also includes documentation requirements, billing codes, and specific models for delivery of telemental health services.

Healthy Families Program

The Healthy Families Program (HFP) is California’s version of the federal Children’s Health Insurance Program. Administered by the Managed Risk Medical Insurance Board (MRMIB), it provides low-cost health, dental, and vision coverage to uninsured, low-income children in California who are not eligible for Medi-Cal. Coverage is available for children up to age 19. HFP enrollees accounted for 134 of

the 5,138 clinical consults in the Anthem BC Telemedicine Network from September 2008 through September 2009.²⁴

HFP does not have a separate policy for contracting health plans to cover telemedicine services, but all HFP contracted health plans are licensed by DMHC and therefore subject to TDA provisions. Since MRMIB provides HFP benefits through contracts with public and private health plans, decisions about reimbursement levels and claims payment are delegated to the contracting plans.

MRMIB has actively advanced the use of telemedicine through the Rural Health Demonstration Projects (RHDP), legislatively authorized grant projects to fund collaborative networks and expanded services for HFP enrollees in rural areas. As part of the RHDP, MRMIB awarded funding to Anthem BC to support development of a telemedicine network and to increase access to specialty care in isolated areas of California. The RHDP supported the network through equipment installations, training, software, technical assistance, and reimbursement. According to the 2007 RHDP Fact Book, 15 telemedicine projects had been funded since 1998, and 75% of those were able to sustain their programs past the point of RHDP funding.²⁵ As a consequence of the state fiscal crisis, RHDP funding was eliminated in the 2009–10 budget.

County Medical Services Program

The County Medical Services Program (CMSP) provides health coverage for low-income, medically indigent adults in 34 primarily rural California counties. CMSP was established in January 1983 to help smaller counties provide services to medically indigent adults.²⁶ CMSP contracts with Anthem BC to administer the program, and Anthem BC in turn contracts with health care providers for emergency and non-emergency services. Four percent of the Anthem BC network telemedicine services in 2008–09 were paid for by CMSP.

While the CMSP is not specifically subject to the reimbursement provisions of the TDA, it has implemented coverage for telemedicine services because of the many rural communities it serves. CMSP provides reimbursement for telemedicine similar to a standard office visit for both live video and store-and-forward consults, including a per-encounter

facility fee for presentation sites. The CMSP provider manual developed by Anthem BC as CMSP administrator includes an extensive telemedicine policy outlining the services and specialties that are available; supporting documentation and coding required for billing purposes; steps for assessing a patient's appropriateness for telemedicine (a decision assigned to the primary care physician) and the appropriate types of telemedicine consultation (including conditions generally suitable for telemedicine); the process for referring members to telemedicine services; and the process for developing and implementing the treatment plan. The CMSP manual recommends that "appropriateness" be assessed based both on what is medically appropriate and what is most convenient for the patient.

V. Conclusions and Recommendations

Enactment of the TDA relatively early in the evolution of telehealth and telemedicine technologies established California as a national leader in telehealth policy. The TDA has improved the chances for reimbursement and coverage of telemedicine in both public and private health care programs, with the greatest advances and successes coming in public and safety net care programs. Health plans and insurers generally comply with the requirements of the TDA; there is no evidence that California health plans require face-to-face contact for reimbursement of telemedicine services.

However, the TDA does not go as far as many advocates and providers hoped it would at the time of its passage. The TDA does not require health plans to have separate and distinct reimbursement policies related to telemedicine; few health plans have such policies. And despite the TDA, complex and disparate billing requirements, along with low aware-

The TDA does not ensure clear or consistent policies on how services provided via telemedicine will be reimbursed.

ness among health plan and medical group claims reviewers, continue to serve as barriers to payment for telemedicine services.

Fundamentally, the TDA does not ensure clear and consistent policies or information regarding how services provided via telemedicine will be covered and reimbursed.

Recommendations

Implementation of the following recommendations would improve the effectiveness of the TDA and ensure that California law and reimbursement policy keep pace with modern technological advances in telehealth and telemedicine.

- **Recommendation 1. Strengthen the TDA.** Ideally, the TDA should be amended to clearly require reimbursement for any medically necessary service covered under the terms of a contract or policy, whether provided in person or through telemedicine. In addition, the TDA should be amended to extend to private health plans Medi-Cal's store-and-forward coverage mandate. At a minimum, the DMHC and CDI should require all health plans and insurers to demonstrate how they comply with the TDA, including describing telemedicine in the EOC as a coverage option.
- **Recommendation 2. Streamline and modernize Medi-Cal coverage.** Medi-Cal coverage policies should be updated with the following changes: 1) Eliminate the requirement that a specific barrier be identified before telemedicine is covered, or at a minimum simplify documentation; 2) Extend Medi-Cal's store-and-forward coverage to any specialty; 3) Expand originating sites to include all approved Medi-Cal providers, or at least the sites added by Medicare in 2009 (skilled nursing facilities, hospital-based dialysis centers, and community health centers);²⁷ and, 4) Revise Medi-Cal managed care plan contracts to incorporate telemedicine coverage.
- **Recommendation 3. Promote telemedicine as a tool for addressing broad goals of quality, efficiency, and access.** As a starting point, payers should eliminate restrictions on the geographic locations, provider sites, or medical specialties where telemedicine will be covered. This would bring policies in line with the growing recognition that telemedicine can overcome numerous barriers to care beyond geographic or distance limitations.
- **Recommendation 4. Standardize billing and coverage procedures.** Experts and stakeholders should develop and disseminate common utilization and reimbursement guidelines by building on the best elements of provider manuals already developed for Medicare, Medi-Cal, CMSP, and county mental health managed care plans.

To encourage adoption of the common guidelines, the TDA could be amended so that use of the guidelines would be considered compliance for regulatory purposes.

- **Recommendation 5. Increase awareness of the TDA.** Many health plans and insurers, providers, and consumers are unaware of the TDA requirements or the availability of telemedicine technologies. State agencies, policy organizations, and provider groups should engage in education and outreach to increase awareness and facilitate expanded use and coverage of telemedicine.
- **Recommendation 6. Acknowledge and establish telemedicine as the standard of care.** Telemedicine has proven it can be an effective tool in pursuit of improved access, reduced costs, and quality outcomes. The current momentum to expand and enhance the use of technology in health care presents an opportunity to more fully integrate telemedicine into health care delivery. For example, new reimbursement methods that reward performance rather than numbers of visits might encourage greater use of telemedicine to meet quality standards. Telemedicine should be actively promoted as part of any health care reform effort.

VI. The Future of Telehealth and Telemedicine Policy

California has been a leader in telehealth and telemedicine adoption and policy. The TDA was a landmark piece of legislation; it legitimized the use of telemedicine as an appropriate form of health care. California law reflects policymakers' recognition that telemedicine and telehealth are tools to transform and improve the care delivery system and the health status of the population. Policymakers can further encourage these improvements by ensuring that California law keeps pace with developments in telehealth technologies.

There is significant momentum now—and new funding—to modernize and strengthen technology and information technology in health care. Technology is only as powerful as the uses to which it is deployed. Telehealth and telemedicine are two uses of technology that serve policymakers'

goals of delivery system and health status improvement. Telemedicine changes the way health care is delivered, the way it is paid for, and the way the health care system is held to account. Policymakers have the opportunity to align California's statutory and regulatory framework for telemedicine to advance these goals.

About the Author

This issue brief was prepared for CCHP by Deborah Reidy Kelch, M.P.P.A., an independent health researcher and president of Kelch Associates, a California-based health policy strategy and research consulting firm.

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Endnotes

1. The mission of CCHP is premised on the promotion of telehealth technologies, which include but are not limited to telemedicine. This issue brief generally uses the term telemedicine, to be consistent with the terminology in the TDA.
2. *Connecting California: The Impact of the Stimulus Package on Broadband and Telehealth Expansion*. California Center for Connected Health: April 2009 (available online at www.connectedhealthca.org).
3. *Telemedicine in California: Progress, Challenges, and Opportunities*. California HealthCare Foundation: July 2008 (obtained online at www.chcf.org).
4. SB 1665 (Thompson, M.), Chapter 864, Statutes of 1996.
5. California Business and Professions Code Section 2290.5.
6. California Health and Safety Code Section 1374.13 and California Insurance Code Section 10123.85.
7. Regulation and oversight of health insurance in California is split between two state departments. The Department of Managed Health Care (DMHC) regulates health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act of 1975. Health maintenance organizations (HMOs) and some preferred provider organization (PPO) plans are included. The California Department of Insurance (CDI) regulates disability insurers offering health insurance (health insurers), including PPO benefit plans and traditional indemnity health insurance coverage. The provisions of the TDA apply to both health plans and health insurers.
8. California Health and Safety Code Section 1374.13 and California Insurance Code Section 10123.85.
9. California Welfare and Institutions Code Section 14132.72 and 14132.725.
10. Analysis of SB 1665 (Thompson, M.). Assembly Committee on Appropriations: August 7, 1996 (obtained online at www.leginfo.ca.gov).
11. DMHC limited the search for telemedicine-related complaints to the last three years, according to a DMHC spokesperson, because of the volume of overall complaints received by the HMO Help Center.
12. Title 28, California Code of Regulations, Division 1, Chapter 2, Article 7, Section 1300.67.2.2.
13. The Medicare telemedicine benefit was established in the federal Balanced Budget Act of 1997 and revised in the Benefits Improvement and Protection Act of 2000 (BIPA).
14. House Resolution 2068 was introduced in May 2009 and co-authored by two Democratic representatives (Mike Thompson of California and Bart Supak of Michigan) and two

Republican representatives (Sam Johnson of Texas and Lee Terry of Nebraska). Several provisions of H.R. 2068 have been included in H.R. 3962, the health care reform bill passed by the House.

15. *Telemedicine and Telehealth: Medicaid Overview*. Centers for Medicare and Medicaid Services: September 15, 2009 (obtained online at www.cms.hhs.gov/Telemedicine).
16. *Telemedicine for CSHCN (Children with Special Health Care Needs): A State-by-State Comparison of Medicaid Reimbursement Policies and Title V Activities*. Institute for Child Health Policy, University of Florida: July 2005 (obtained online at www.ichp.ufl.edu).
17. *Telemedicine Reimbursement: A National Scan of Current Policies and Emerging Initiatives*. California Telemedicine and eHealth Center: April 2009 (obtained online at www.cteonline.org).
18. *Medicaid Reimbursement*. Center for Telehealth and E-Health Law: December 2009 (obtained online at www.telehealthlawcenter.org).
19. *Medi-Cal Provider Manual: Telemedicine*. Department of Health Care Services: October 2008 (obtained online at www.dhcs.ca.gov).
20. The County Mental Health plan manual published by the California Institute of Mental Health defines telemental health and telepsychiatry services as “psychiatric or mental health services delivered ‘real time’ using the latest technology in teleconferencing and equipment.”
21. California Institute of Mental Health (CIMH) is a nonprofit organization providing mental health–related training, technical assistance, research, and policy development in California.
22. *Telemental Health and Telepsychiatry Operations and Implementation Manual for County Mental Health Plans*. California Institute for Mental Health: November 2002 (obtained online at www.cimh.org).
23. Ibid.
24. Data supplied by Anthem BC.
25. *Rural Health Demonstration Projects: Fact Book 2007*. California Managed Risk Medical Insurance Board: April 18, 2007 (obtained online at www.mrmib.ca.gov).
26. More information on the history of the CMSP can be found at www.cmsspcounties.org/about/history.html.
27. *School-based Telehealth: An Innovative Approach to Meet the Health Care Needs of California’s Children*. The Children’s Partnership: October 2009. Digital Opportunity for Youth Issue Brief Number 6 (available online at www.childrenspartnership.org).

Center for Connected Health Policy

The Center for Connected Health Policy (CCHP) is a nonprofit planning and strategy organization working to remove policy barriers that prevent the integration of telehealth technologies into California’s health care system.

Telehealth technologies are tools for improving health outcomes and access to care, particularly among uninsured and low-income Californians, and for making the state’s health care system more efficient and cost-effective. CCHP advocates for policies that expand telehealth services in pursuit of these goals.

CCHP conducts objective policy analysis and research, develops nonpartisan policy recommendations, and operates telehealth demonstration projects.

www.ConnectedHealthCA.org



Appendix

Telemedicine Development Act of 1996 (As amended through January 1, 2010)

Legislative Intent

The Legislature finds and declares all of the following:

- (a) Lack of primary care, specialty providers, and transportation continue to be significant barriers to access to health services in medically underserved rural and urban areas.
- (b) Parts of California have difficulty attracting and retaining health professionals, as well as supporting local health facilities to provide a continuum of health care. As of June, 1995, 49 counties received federal designation as having medically underserved areas or populations.
- (c) Many health care providers in medically underserved areas are isolated from mentors, colleagues, and the information resources necessary to support them personally and professionally.
- (d) Telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another.
- (e) Telemedicine is part of a multifaceted approach to address the problem of provider distribution and the development of health systems in medically underserved areas by improving communication capabilities and providing convenient access to up-to-date information, consultations, and other forms of support.
- (f) The use of telecommunications to deliver health services has the potential to reduce costs, improve quality, change the conditions of practice, and improve access to health care in rural and other medically underserved areas.
- (g) Telemedicine has been utilized in one form or another for 30 years, and telemedicine projects currently exist in at least 40 states.
- (h) Telemedicine will assist in maintaining or improving the physical and economic health of medically underserved communities by keeping the source of medical care in the local area, strengthening the health infrastructure, and preserving health care–related jobs.
- (i) Consumers of health care will benefit from telemedicine in many ways, including expanded access to providers, faster and more convenient treatment, better continuity of care, reduction of lost work time and travel costs, and the ability to remain with support networks.

- (j) Telemedicine does not change the existing scope of practice of any licensed health professional.
- (k) It is the intent of the Legislature that telemedicine not replace health care providers or relegate them to a less important role in the delivery of health care. The fundamental health care provider–patient relationship can not only be preserved, but also augmented and enhanced, through the use of telemedicine.
- (l) Without the assurance of payment and the resolution of legal and policy barriers, the full potential of telemedicine will not be realized.
- (m) **This act shall be known as the “Telemedicine Development Act of 1996.”**

This act shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

Health Care Practitioners; Telemedicine Defined

Business and Professions Code Section 2290.5:

- (a) (1) For the purposes of this section, “telemedicine” means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes “telemedicine” for purposes of this section.
 - (2) For purposes of this section, “interactive” means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.
- (b) For the purposes of this section, “health care practitioner” has the same meaning as “licentiate” as defined in paragraph (2) of subdivision (a) of Section 805 and also includes a person licensed as an optometrist pursuant to Chapter 7 (commencing with Section 3000).
- (c) Prior to the delivery of health care via telemedicine, the health care practitioner who has ultimate authority over the care or primary diagnosis of the patient shall obtain verbal and written informed consent from the patient or the patient’s legal representative. The informed consent procedure shall ensure that at least all of the following information is given to the patient or the patient’s legal representative verbally and in writing:

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- (1) The patient or the patient's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the patient or the patient's legal representative would otherwise be entitled.
 - (2) A description of the potential risks, consequences, and benefits of telemedicine.
 - (3) All existing confidentiality protections apply.
 - (4) All existing laws regarding patient access to medical information and copies of medical records apply.
 - (5) Dissemination of any patient identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the patient.
- (d) A patient or the patient's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the patient or the patient's legal representative understands the written information provided pursuant to subdivision (a), and that this information has been discussed with the health care practitioner, or his or her designee.
 - (e) The written consent statement signed by the patient or the patient's legal representative shall become part of the patient's medical record.
 - (f) The failure of a health care practitioner to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.
 - (g) All existing laws regarding surrogate decisionmaking shall apply. For purposes of this section, "surrogate decisionmaking" means any decision made in the practice of medicine by a parent or legal representative for a minor or an incapacitated or incompetent individual.
 - (h) Except as provided in paragraph (3) of subdivision (c), this section shall not apply when the patient is not directly involved in the telemedicine interaction, for example when one health care practitioner consults with another health care practitioner.
 - (i) This section shall not apply in an emergency situation in which a patient is unable to give informed consent and the representative of that patient is not available in a timely manner.
 - (j) This section shall not apply to a patient under the jurisdiction of the Department of Corrections or any other correctional facility.

- (k) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

Business and Professions Code Section 2060:

Nothing in this chapter [*physician licensure laws*] applies to any practitioner located outside this state, when in actual consultation, whether within this state or across state lines, with a licensed practitioner of this state, or when an invited guest of the California Medical Association or the California Podiatric Medical Association, or one of their component county societies, or of an approved medical or podiatric medical school or college for the sole purpose of engaging in professional education through lectures, clinics, or demonstrations, if he or she is, at the time of the consultation, lecture, or demonstration a licensed physician and surgeon or a licensed doctor of podiatric medicine in the state or country in which he or she resides. This practitioner shall not open an office, appoint a place to meet patients, receive calls from patients within the limits of this state, give orders, or have ultimate authority over the care or primary diagnosis of a patient who is located within this state.

Health Care Service Plans

(Subject to the jurisdiction of Department of Managed Health Care)

Health and Safety Code Section 1367:

A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:

- (a) Facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health Services, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.
- (b) Personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.
- (c) Equipment required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law.
- (d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other

providers at times as may be appropriate consistent with good professional practice.

- (e) (1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.
- (2) **To the extent that telemedicine services are appropriately provided through telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these services shall be considered in determining compliance with Section 1300.67.2 of Title 28 of the California Code of Regulations.** *[Regulations related to access to care.]*
- (3) The plan shall make all services accessible and appropriate consistent with Section 1367.04.
- (f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.
- (g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.
- (h) (1) Contracts with subscribers and enrollees, including group contracts, and contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.
- (2) A health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.
- (3) On and after January 1, 2002, a health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes.

- (i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.
- (j) A health care service plan shall not require registration under the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code.

Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services.

The director's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.

The obligation of the plan to comply with this section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.

Health and Safety Code Section 1374.13:

- (a) It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.
- (b) For the purposes of this section, the meaning of "telemedicine" is as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.
- (c) On and after January 1, 1997, no health care service plan contract that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the

contract agreed upon between the enrollee or subscriber and the plan. The requirement of this subdivision shall be operative for health care service plan contracts with the Medi-Cal managed care program only to the extent that both of the following apply:

(1) Telemedicine services are covered by, and reimbursed under, the Medi-Cal fee-for-service program, as provided in subdivision (c) of Section 14132.72.

(2) Medi-Cal contracts with health care service plans are amended to add coverage of telemedicine services and make any appropriate capitation rate adjustments.

(d) Health care service plans shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

Health and Safety Code Section 1375.1:

(a) Every plan shall have and shall demonstrate to the director that it has all of the following:

(1) A fiscally sound operation and adequate provision against the risk of insolvency.

(2) Assumed full financial risk on a prospective basis for the provision of covered health care services, except that a plan may obtain insurance or make other arrangements for the cost of providing to any subscriber or enrollee covered health care services, the aggregate value of which exceeds five thousand dollars (\$5,000) in any year, for the cost of covered health care services provided to its members other than through the plan because medical necessity required their provision before they could be secured through the plan, and for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for that fiscal year.

(3) A procedure for prompt payment or denial of provider and subscriber or enrollee claims, **including those telemedicine services, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, covered by the plan.** Except as provided in Section 1371, a procedure meeting the requirements of Subchapter G of the regulations (29 C.F.R. Part 2560) under Public Law 93-406 (88 Stats.829-1035, 29 U.S.C. Secs. 1001 et seq.) shall satisfy this requirement.

(b) In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the following:

(1) The financial soundness of the plan's arrangements for health care services and the schedule of rates and charges used by the plan.

(2) The adequacy of working capital.

(3) Agreements with providers for the provision of health care services.

(c) For the purposes of this section, "covered health care services" means health care services provided under all plan contracts.

Health Insurers

(Subject to the jurisdiction of California Department of Insurance)

Insurance Code Section 10123.13:

(a) Every insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses, **including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code,** shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses as soon as practical, but no later than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting or denying the claim. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason for contesting or denying the claim. The insurer shall provide a copy of the notice to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice shall advise the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that the insurer contested or denied, and the notice shall include the address, Internet Web site address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. The notice to the insured may also be included on the explanation of benefits.

- (b) If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 30 working days after receipt, interest shall accrue and shall be payable at the rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.
- (c) For purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant. If an insurer has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim determined to be payable within 30 working days of receipt of that information, interest shall accrue and be payable at a rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.
- (d) The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

Insurance Code Section 10123.85:

- (a) It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.
- (b) For the purposes of this section, the meaning of "telemedicine" is as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.
- (c) On and after January 1, 1997, no disability insurance contract that is issued, amended, or renewed for hospital, medical, or surgical coverage shall require face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the contract agreed upon between the policyholder or contractholder and the insurer.
- (d) Disability insurers shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

Medi-Cal

Welfare and Institutions Code Section 14132.72:

- (a) It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.
- (b) For the purposes of this section, "telemedicine" and "interactive" are defined as those terms are defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.
- (c) (1) Commencing July 1, 1997, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telemedicine, subject to reimbursement policies developed by the Medi-Cal program to compensate licensed health care providers who provide health care services, that are otherwise covered by the Medi-Cal program, through telemedicine. The audio and visual telemedicine system used shall, at a minimum, have the capability of meeting the procedural definition of the Current Procedural Terminology Fourth Edition (CPT-4) codes which represent the service provided through telemedicine. The telecommunications equipment shall be of a level of quality to adequately complete all necessary components to document the level of service for the CPT-4 code billed. If a peripheral diagnostic scope is required to assess the patient, it shall provide adequate resolution or audio quality for decisionmaking.
- (2) The department shall report to the appropriate committees of the Legislature, by January 1, 2000, on the application of telemedicine to provide home health care; emergency care; critical and intensive care, including neonatal care; psychiatric evaluation; psychotherapy; and medical management as potential Medi-Cal benefits.
- (d) The Medi-Cal program shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.
- (e) The Medi-Cal program shall pursue private or federal funding to conduct an evaluation of the cost-effectiveness and quality of health care provided through telemedicine by those providers who are reimbursed for telemedicine services by the program.

Welfare and Institutions Code Section 14132.725:

- (a) Commencing July 1, 2006, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for teleophthalmology and teledermatology by store and forward. Services appropriately provided through the store and forward process are subject to billing and reimbursement policies developed by the department.
- (b) For purposes of this section, “teleophthalmology and teledermatology by store and forward” means an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology, where the physician at the distant site reviews the medical information without the patient being present in real time. A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician, and shall receive an interactive communication with the distant specialist physician, upon request. If requested, communication with the distant specialist physician may occur either at the time of the consultation, or within 30 days of the patient’s notification of the results of the consultation.
- (c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all county letters, provider bulletins, and similar instructions.
- (d) On or before January 1, 2008, the department shall report to the Legislature the number and type of services provided, and the payments made related to the application of store and forward telemedicine as provided, under this section as a Medi-Cal benefit.
- (e) The health care provider shall comply with the informed consent provisions of subdivisions (c) to (g), inclusive, of, and subdivisions (i) and (j) of, Section 2290.5 of the Business and Professions Code when a patient receives teleophthalmology or teledermatology by store and forward.
- (f) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

Welfare and Institutions Code Section 14132.73:

The State Department of Health Services shall allow psychiatrists to receive fee-for-service Medi-Cal reimbursement for services provided through telemedicine until June 30, 2004, or until the State Department of Mental Health and mental health plans, in collaboration with stakeholders, develop a method for reimbursing psychiatric services provided through telemedicine that is administratively feasible for the mental health plans, primary care providers, and psychiatrists providing the services, whichever occurs later.

Other Provisions

Health and Safety Code Section 123149.5:

- (a) It is the intent of the Legislature that all medical information transmitted during the delivery of health care via telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, become part of the patient’s medical record maintained by the licensed health care provider.
- (b) This section shall not be construed to limit or waive any of the requirements of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.