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Important Developments in Telemedicine

The realization of the full potential of telemedicine has taken longer than many of us anticipated, but the COVID-19 pandemic may finally bring about that realization.

By Francis J. Serbaroli, Skip Short and Ioanna Zevgaras| November 10, 2020 | New York Law Journal

The COVID-19 virus has wreaked havoc upon human lives, our economy, and our health care system. When the full extent of the danger posed by this virus became known, hospitals cancelled virtually all elective surgeries in order to have the capacity to treat what was expected to be a high volume of patients infected with the virus who would need acute care. The demand for ventilators and personal protective equipment (PPE) skyrocketed. Patients sometimes shared a single ventilator, and physicians, nurses and hospital staff had to re-use PPE and improvise in numerous other ways.

Hospitals and physician practices cancelled outpatient visits, and patients themselves have grown wary of going to their health care providers, fearing that they could become infected by providers, other patients, or during their commute to and from an office visit. Countless numbers of patients have postponed getting medical care and treatment, and only time will tell what effect these postponements will have on the health of the general population.

One of the many interesting developments in health care arising from the COVID-19 pandemic is the sharp rise in telemedicine encounters to facilitate patients' access to health care providers. Telemedicine is not new, but up until now, its potential has not been fully realized. It has been deployed in emergency situations, for example, when paramedics reach a patient's home and consult with emergency room physicians on stabilizing the patient prior to transportation to the emergency room. More recently, telemedicine has been used successfully in nursing homes to assess a patient's medical conditions remotely, thereby preventing unnecessary, disruptive, and costly trips to the hospital. Telemedicine has also been instrumental in

bringing access to health care services to people in rural areas, and has contributed to more efficient care of patients with chronic medical problems, or mental or behavioral health issues.

The federal Centers for Disease Control (CDC) issued **guidance** on telemedicine and the COVID-19 virus on June 20, 2020. The CDC observed:

Telehealth services can facilitate public health migration strategies during this pandemic by increasing social distancing. These services can be a safer option for [health care personnel] HCP and patients by reducing potential infectious exposures. They can reduce the strain on health care systems by minimizing the surge of patient demand on facilities and reduce the use of [personal protective equipment] PPE by health care providers.

The CDC cited some of the medium's many advantages:

Maintaining continuity of care to the extent possible can avoid additional negative consequences from delayed preventive, chronic, or routine care. Remote access to health care services may increase participation for those who are medically or socially vulnerable or who do not have ready access to providers. Remote access can also help preserve the patient-provider relationship at times when an in-person visit is not practical or feasible.

Among the strategies for increasing access to telemedicine services, the CDC cited the following:

- Communicate with insurers/payers to understand availability of covered telehealth, telemedicine, or nurse advice line services;
- Use tele-triage methods for assessing and caring for all patients to decrease the volume of persons seeking care in facilities, especially during times of high transmission of contagious diseases such as COVID-19.
- Provide outreach to patients with limited technology and connectivity and offer flexibility in platforms that can be used for video consultation, or non-video options, when possible.
- Include options for language interpretation, as needed.

Definition

Telemedicine is sometimes referred to variously as e-health, telehealth, and virtual consults. However, the federal Centers for Medicare and Medicaid Services (CMS) differentiate the terms telehealth and telemedicine for reimbursement purposes. CMS's Medicaid **website** states:

For purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Telehealth (or Telemonitoring) is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

Thus, CMS uses "telemedicine" to refer to the actual remote clinical services being provided, and "telehealth" to refer to the technology used in enabling the provision of remote clinical services.

A key condition for payment for telemedicine services by Medicare, Medicaid and other government health benefit programs is that physicians and other providers practice within the scope of what is permitted by state licensing statutes. Each state has its own approach to regulating telemedicine, so let's go over what New York law allows and doesn't allow.

New York Public Health Law (PHL) §2999-cc(5) defines telemedicine as:

… the use of synchronous, two-way electronic audio visual communications to deliver clinical health care services, which shall include the assessment, diagnosis, and treatment of a patient, while such patient is at the originating site and a telehealth provider is at a distant site.

The law authorizes the following New York-licensed professionals/entities to be telehealth providers:

- physician
- physician assistant
- dentist
- nurse practitioner
- registered professional nurse
- podiatrist
- optometrist
- psychologist
- social worker
- speech language pathologist
- audiologist
- midwife
- hospital
- home care services agency
- hospice
- any other provider authorized by the Commissioner of the Department of Health (DOH)

The law also authorizes the following to be telehealth providers as long as they have been certified by their respective specialty Boards:

- diabetes educator
- asthma educator

- genetic counselor

New York's Education Law (Ed. Law) §6521 defines the practice of medicine as "diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition." Ed. Law §6522 requires that "Only a person licensed or otherwise authorized under this article shall practice medicine or use the title 'physician'." Accordingly, a physician (or other authorized practitioner) who wishes to diagnose and treat a patient located in New York by way of telemedicine must be licensed in New York.

Ed. Law §6526 contains very narrowly tailored exceptions to this licensing requirement. A relevant exception is §6526(2), which allows a physician licensed in a state that borders New York and resides near a New York border to practice medicine as long as the physician's practice in New York is limited to the vicinity of the border, and as long as the physician "does not maintain an office or place to meet patients or receive calls" within New York. Another exception is §6526(3), which allows a physician licensed in another state or country to practice medicine only to the extent that the foreign physician is meeting a physician who is licensed in New York for purposes of consultation, and only to the extent of the consultation.

Yet another exception would seem to be in the case of a patient who resides in New York, travels to New Jersey and establishes a physician-patient relationship with a New Jersey-licensed physician, and is treated in the physician's New Jersey office. Follow-up care by the New Jersey physician via telemedicine when the patient returns to New York would seem to be appropriate as long as it is limited to the medical problem for which the patient sought care in New Jersey in the first instance. Ongoing care of the patient for other medical conditions would require the physician to obtain a New York license if the care is to be provided via telemedicine; otherwise, the patient must travel to New Jersey for further care and treatment.

Assuming a physician is licensed in New York and using telemedicine to treat patients, most other requirements of an office visit apply:

1. A physician-patient relationship must exist. If a physician, physician assistant, or other licensed practitioner provides professional advice, treatment or therapy, there is then a presumption that a professional relationship has been established whether or not the patient has been charged or paid a fee for the service.

2. The physician must display or otherwise make available to the patient a copy of the physician's medical license, either before or during the initial telemedicine encounter.

3. The physician must keep an accurate medical record of the telemedicine consultation, either on paper or as part of an electronic medical record. If the physician wishes to record and store a video of the encounter, it must be with the patient's prior consent.

4. The patient must give his/her informed consent to any treatment or procedure.

5. The physician must exercise good medical judgment in determining whether a telemedicine encounter is appropriate for diagnosis and treatment, or whether a face-to-face encounter with the patient is needed. Once a physician-patient relationship has been established, the physician must be accessible for follow-up care and consultation as needed.

6. The physician must safeguard the privacy of the telemedicine encounter itself, the record kept of the encounter, and any subsequent exchange or transfer of the patient's personal health information to authorized third parties in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy rules and applicable state law.

7. If the physician will be billing for the telemedicine encounter, the physician should make certain beforehand that the encounter is reimbursable *and* that it is conducted in accordance with and meets all requirements of the third-party payor, be it Medicare, Medicaid, or a private insurer or plan.

8. The physician should also make certain beforehand that whatever professional liability insurance policy covers her practice includes coverage for telemedicine encounters.

Payment

At its advent, government, doctors and patients were skeptical regarding telemedicine. As the use of technology became more common and reliable, rising medical costs and rural access barriers to specialty health care have been among the factors that have resulted in the expanded use of telemedicine. In December 2014, New York became the 22nd state to enact a telehealth parity law requiring commercial insurers and Medicaid to cover telehealth services like traditional in-person care. PHL Article 29-G, Social Services Law §367- u, and Insurance Law §3217-h.

There has been considerable expansion of the use of telehealth during the current COVID-19 crisis and a significant number of executive and regulatory actions have been taken to facilitate this expansion. Early in the crisis, Governor Andrew Cuomo issued a March 7, 2020, Executive Order 202 declaring a state of emergency. On March 12, 2020, with Executive Order Number 202.1, Governor Cuomo suspended PHL §2999-cc and relaxed which types of providers are eligible to provide telehealth services. The Governor also expanded telehealth to include non-video telephone communications during the State of Emergency.

The Department of Financial Services (DFS), in its Insurance Circular Letter No. 6 of 2020, directed that:

Use of telehealth is essential to reduce the spread of COVID-19 and to ensure access to covered services, whether or not related to COVID-19. Issuers and prepaid health services plans should ensure that telephonic and video modalities are covered for telehealth when medically appropriate for the provision of services covered under a policy or contract, including Medicaid coverage.

The DFS also promulgated an emergency regulation on March 16, 2020, ensuring that patients would not be held responsible for any out-of-pocket costs associated with telemedicine visits during the State of Emergency. The regulation did not limit reimbursement to COVID-related services. Accepted telehealth technologies include telephonic or video modalities including technology commonly available on smart phones and other devices. 11 NYCRR 52.16(q). (effective until Sept. 8, 2020)

The Workers' Compensation Board adopted emergency amendments to 12 NYCRR 325-1.8, 329-1.3, 329-4.2, 333.2, and 348.2 to expand telehealth for workers compensation and no-fault insurance. The Board stated it was doing so in the May 6, 2020 State Register "to avoid health and safety risks that can be avoided through social distancing" during the COVID-19 crisis. The Amendments are effective until October 18, 2020, and they provide a code method to allow for telemedicine by two-way audio and visual communication as well as telephone visits. Although the State Board has not made telemedicine a permanent part of the chiropractic scope of practice, chiropractors are listed as authorized providers during the emergency.

The CMS provided for some limited telehealth services prior to the COVID-19 crisis. As noted earlier, CMS allowed payment for such services in rural areas, with virtual check-ins and e-visits. These services were expanded in response to the COVID-19 public health emergency to allow payment for professional services

furnished to beneficiaries in all areas of the country and in all settings including in the patient's place of residence. CMS authorized extensive telehealth services for the duration of the crisis, and noted:

The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home. These changes are to continue for the duration of the public health emergency.

CMS further expanded the allowable types of clinicians and medical services that could be reimbursed. For example, hospitals are now able to bill for outpatient services provided remotely to patients at home. Similar authorizations were extended to physical and occupational therapists, speech language pathologists, behavioral health and patient education service providers, nurse practitioners, clinical psychologists and licensed clinical social workers. Reimbursements for such services were increased to match the payment rates for in-person visits, retroactive to March 1, 2020.

CMS granted New York's COVID-19 related state Medicaid Section 1135 request to waive certain federal health care requirements. These waivers provide relief in a number of areas, such as facilitating reimbursement for care delivered in alternative settings due to facility evacuations, requirements for prior authorization and provider enrollment, preexisting relationships, and suspension of nursing home pre-admission reviews. They also provided for the temporary delay of Medicaid hearings.

New York's DOH promoted telephonic evaluation and management services for Medicaid beneficiaries effective for dates of service on or after March 1, 2020, for the duration of the State of Emergency. Medicaid-reimbursable services were temporarily expanded to include telephonic and/or video including technology commonly available, such as smart phones, tablets, and other devices. All services authorized within a provider's scope of practice can thus be provided through telemedicine.

Prior to the current pandemic, New York reimbursed claims from out-of-state providers not enrolled in the New York Medicaid program if the following criteria were met:

1. The item or service is furnished by an institutional provider, individual practitioner, or pharmacy at an out-of-state/territory practice location– i.e., located outside the geographical boundaries of the reimbursing state/territory's Medicaid plan,

2. The National Provider Identifier (NPI) of the furnishing provider is represented on the claim,

3. The furnishing provider is enrolled and in an "approved" status in Medicare or in another state/territory's Medicaid plan, and

4. The claim represents services furnished.

5. The claim represents either:

    a. A single instance of care furnished over a 180-day period, or

    b. Multiple instances of care furnished to a single participant, over a 180-day period.

Section 1135 waivers by CMS afforded further flexibility for reimbursement of payable claims by out-of-state licensed providers not enrolled in New York's Medicaid program, subject to certain conditions. During the public health emergency, CMS has waived the fifth requirement above, where services were provided to Medicaid participants enrolled under New York's Medicaid program. As a result, Medicaid can reimburse

out-of-state providers for multiple instances of care to multiple participants, so long as the other applicable criteria are met.

Other government agencies have issued guidance encouraging the use of telehealth to manage patients. For example, the U.S. Department of Health & Human Services' Office for Civil Rights relaxed HIPAA requirements and announced that they will not impose penalties for noncompliance by health care providers providing telehealth services.

The Office of the Professions of the New York Department of Education issued occupation-specific telepractice guidance and recognized the Executive Order suspending PHL §2999-cc and authorizing audio-only phone, e-mail, chat and videoconferencing for telepractice.

Telemedicine, Fraud and Security Breaches

Accompanying this expansion of telemedicine services is the potential for fraud and abuse affecting patients, health care providers, and third-party payors. The potential includes schemes similar to those targeting regular health services where the patient and doctor are physically present, and include new possibilities based upon the medium for health provider and patient contacts.

Telehealth fraud has been part of the health care system for many years. Two recent prosecutions initiated prior to the COVID-19 crisis illustrate this point. On February 5th of this year, the Department of Justice (DOJ) announced charges against two owners of telemedicine companies for their roles in a $56 million conspiracy to defraud Medicare and receive illegal kickbacks in exchange for orders for orthotic braces. The defendants had multiple offices including one in New Jersey. In another case, in October 2018, the DOJ announced guilty pleas in a billion dollar telemedicine scheme that defrauded patients, doctors and insurers. The indictment alleged a scheme in which the defendants fraudulently solicited insurance coverage information and prescriptions from consumers across the country for prescription pain creams and other similar products. The consumers' physicians approved the prescriptions unaware of the defendants' huge markups of improperly prescribed drugs, which the defendants then billed to private insurance carriers. In total the defendants allegedly submitted at least $931,000,000 in fraudulent claims.

On April 23rd of this year, in announcing indictments in still another telemedicine scheme the DOJ warned:

As telemedicine becomes an increasing part of our health care system, vigilance in ensuring that fraud and kickbacks do not usurp the legitimate practice of medicine by electronic means is more important than ever.

In addition to traditional schemes involving illegal kickbacks and self-referrals, telemedicine is susceptible to other abuse because of the lack of face-to-face contact between health providers and patients. Identity theft, hacking for health care and insurance information, taking advantage of decreased portal security in times of stress, and falsification of the actual services provided are all more likely in the current COVID-19 environment. The waiving of deductibles and copays by Medicare during the crisis has also potentially encouraged illegal kickbacks, and less vigilance by patients in scrutinizing bills for medical services.

The relaxation of privacy rules during the COVID-19 crisis and the use of social media platforms to conduct telehealth communications also has increased the risk of hackers—especially foreign hackers—who have already targeted the health care payment system in the past. Access to patient health information and e-mails to parties already expecting them creates openings for hackers. Interpol has issued an alert for ransomware attacks on health care organizations and infrastructure engaged in the virus response, especially hospitals. It has warned that e-mails are a primary method used by the ransomware attackers,

particularly e-mails claiming to be from government entities during the crisis. Recent news stories and reported numerous successful Ransomware attacks on hospitals across the country.

On March 23, 2020, the U.S. Department of Health and Human Services Office of Inspector General issued a fraud alert for schemes during the COVID-19 period and warned of attempts to gain patient insurance information through telemarketing and text messages.

Moreover, the professional licensing rules exist to protect patients. While the advent of electronically stored information has created some benefits and efficiencies for patients and their health care providers, it has also created a great risk of access. Huge amounts of data already have been accessed by hackers. It is essential that any relaxation of the laws and regulations governing face-to-face doctor-patient encounters be done carefully, with emphasis on protection of patients' health care information.

Conclusion

The realization of the full potential of telemedicine has taken longer than many of us anticipated, but the COVID-19 pandemic may finally bring about that realization. As technology continues to improve, more medical conditions will be able to be diagnosed and treated from a distance. Of course, office visits will continue to be a substantial portion of patient encounters with medical professionals, but the costs, convenience and safety of telemedicine encounters make a compelling case for the medium's growth.

Unfortunately, as with almost any innovation, bad actors both domestic and foreign have sought and will continue to seek ways to exploit and disrupt telemedicine for their own purposes. Cybersecurity and anti-fraud protections will have to become more sophisticated and aggressive, requiring a greater investment of money, talent and resources. As is the case with most major innovations, real challenges accompany new opportunities.

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