Telemedicine/Telehealth Services/Virtual Visits

Policy Number: BIP182.J
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Instructions for Use

Table of Contents Page

Federal/State Mandated Regulations 1
State Market Plan Enhancements 9
Covered Benefits 9
Not Covered 9
Definitions 9
Policy History/Revision Information 10
Instructions for Use 10

Related Benefit Interpretation Policy

- Physician Services: Primary Care and Specialist Visits

Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

Oklahoma

OAC 435:10-1-4: Definitions

http://www.oar.state.ok.us/viewhtml/435_10-1-4.htm

"Telemedicine" means the practice of healthcare delivery, diagnosis, consultation, treatment, including but not limited to, the treatment and prevention of conditions appropriate to treatment by telemedicine management, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. Telemedicine is not a consultation provided by telephone or facsimile machine (Oklahoma Statutes, Title 36, Sec. 6802). This definition excludes phone or Internet contact or prescribing and other forms of communication, such as web-based video, that might occur between parties that does not meet the equipment requirements as specified in OAC 435:10-7-13 and therefore requires an actual face-to-face encounter. Telemedicine physicians who meet the requirements of OAC 435:10-7-13 do not require a face to face encounter

435:10-7-13. Telemedicine

http://www.oar.state.ok.us/viewhtml/435_10-7-13.htm

a) Physicians treating patients in Oklahoma through telemedicine must be fully licensed to practice medicine in Oklahoma; and
b) Must practice telemedicine in compliance with standards established in these rules. In order to be exempt from the face-to-face meeting requirement set out in these rules, the telemedicine encounter must meet the following:
    1) Telemedicine encounters. Telemedicine encounters require the distant site physician to perform an exam of a patient at a separate, remote originating site location. In order to accomplish this, and if the distant site physician deems it to be medically necessary, a licensed healthcare provider trained in the use of the equipment may be utilized at the originating site to "present" the patient, manage the cameras, and perform any physical activities to successfully complete the exam. A medical record must be kept and be accessible at both the distant and originating sites, preferably a shared Electronic Medical Record, that is full and complete and meets the standards as a valid medical record. There should be provisions for appropriate follow up care equivalent to that available to face-to-face patients. The information available to the distant site physician for the medical problem to be addressed must be equivalent in scope and quality to what would be obtained with an original or follow-up face-to-face encounter and must meet all applicable standards of care for that medical problem including the documentation of a history, a physical exam, the

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ordering of any diagnostic tests, making a diagnosis and initiating a treatment plan with appropriate discussion and informed consent.

2) Equipment and technical standards
   A. Telemedicine technology must be sufficient to provide the same information to the provider as if the exam has been performed face-to-face.
   B. Telemedicine encounters must comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) security measures to ensure that all patient communications and records are secure and remain confidential.
3) Technology guidelines
   A. Audio and video equipment must permit interactive, real-time communications.
   B. Technology must be HIPAA compliant.
4) Board Approval of Telemedicine. In the event a specific telemedicine program is outside the parameters of these rules, the Board reserves the right to approve or deny the program.

OK §36-6801

https://law.justia.com/codes/oklahoma/2014/title-36/section-36-6801
This act shall be known and may be cited as the "Oklahoma Telemedicine Act".
Added by Laws 1997, c. 209, § 1, eff. July 1, 1997.

§36-6802-Definition of "Telemedicine"

https://law.justia.com/codes/oklahoma/2014/title-36/section-36-6802/
As used in this act, "telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, including but not limited to, the treatment and prevention of strokes, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. Telemedicine is not a consultation provided by telephone or facsimile machine.

§36-6803-Telemedicine Services

https://law.justia.com/codes/oklahoma/2014/title-36/section-36-6803/
A. For services that a health care practitioner determines to be appropriately provided by means of telemedicine, health care service plans, disability insurer programs, workers' compensation programs, or state Medicaid managed care program contracts issued, amended, or renewed on or after January 1, 1998, shall not require person-to-person contact between a health care practitioner and a patient.
B. Subsection A of this section shall apply to health care service plan contracts with the state Medicaid managed care program only to the extent that both of the following apply:
   1. Telemedicine services are covered by, and reimbursed under, the fee-for-service provisions of the state Medicaid managed care program; and
   2. State Medicaid managed care program contracts with health care service plans are amended to add coverage of telemedicine services and make any appropriate capitation rate adjustments.

   Added by Laws 1997, c. 209, § 3, eff. July 1, 1997.

Oregon

ORS 743A.058 Telemedical Services

https://www.oregonlaws.org/ors/743A.058
1) As used in this section:
   a) "Health benefit plan" has the meaning given that term in ORS 743B.005 .
   b) "Health professional" means a person licensed, certified or registered in this state to provide health care services or supplies.
   c) "Originating site" means the physical location of the patient.
2) A health benefit plan must provide coverage of a health service that is provided using synchronous two-way interactive video conferencing if:
   a) The plan provides coverage of the health service when provided in person by a health professional;
   b) The health service is medically necessary;
   c) The health service is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and

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    d) The application and technology used to provide the health service meet all standards required by state and federal laws governing the privacy and security of protected health information.
3) A health benefit plan may not distinguish between rural and urban originating sites in providing coverage under subsection (2) of this section.
4) The coverage under subsection (2) of this section is subject to:
    a) The terms and conditions of the health benefit plan; and
    b) The reimbursement specified in the contract between the plan and the health professional.
5) This section does not require a health benefit plan to reimburse a health professional:
    a) For a health service that is not a covered benefit under the plan; or
    b) Who has not contracted with the plan. [2009 c.384 §2; 2015 c.340 §1; 2017 c.309 §5]

ORS 743A.058 Telemedical Services (Effective 06/01/2021)

https://www.oregonlaws.org/ors/743A.058

(1) As used in this section:
    a) (A) "Audio only" means the use of audio telephone technology, permitting real-time communication between a health care provider and a patient for the purpose of diagnosis, consultation or treatment.
        (B) "Audio only" does not include:
            (i) The use of facsimile, electronic mail or text messages.
            (ii) The delivery of health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care provider, such as the sharing of laboratory results.
    b) "Health benefit plan" has the meaning given that term in ORS 743B.005 .
    c) "Health professional" means a person licensed, certified or registered in this state to provide health care services or supplies.
    d) "Health service" means physical, oral and behavioral health treatment or service provided by a health professional.
    e) "Originating site" means the physical location of the patient.
    f) "State of emergency" includes:
        (A) A state of emergency declared by the Governor under ORS 401.165; or
        (B) A state of public health emergency declared by the Governor under ORS 433.441.
    g) "Telemedicine" means the mode of delivering health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a patient's health care.
(2) A health benefit plan and a dental-only must provide coverage of a health service that is provided using [synchronous two-way interactive video conferencing] telemedicine if:
    a) The plan provides coverage of the health service when provided in person by a health professional;
    b) The health service is medically necessary;
    c) The health service is determined to be safely and effectively provided [using synchronous two-way interactive video conferencing] using telemedicine according to generally accepted health care practices and standards; and
    d) The application and technology used to provide the health service meet all standards required by state and federal laws governing the privacy and security of protected health information.
(3) Except as provided in subsection (4) of this section, permissible telemedicine applications and technologies include:
    (a) Landlines, wireless communications, the Internet and telephone networks; and
    (b) Synchronous or asynchronous transmissions using audio only, video only, audio and video and transmission of data from remote monitoring devices.
(4) During a state of emergency, a health benefit plan or dental-only plan shall provide coverage of a telemedicine service delivered to an enrollee residing in the geographic area specified in the declaration of the state of emergency, if the telemedicine service is delivered using any commonly available technology, regardless of whether the technology meets all standards required by state and federal laws governing the privacy and security of protected health information.
(5) A health benefit plan and a dental-only plan may not:
    (a) Distinguish between rural and urban originating sites in providing coverage under subsection (2) of this section or restrict originating sites that qualify for reimbursement.
    (b) Restrict a health care provider to delivering services only in person or only via telemedicine.
    (c) Use telemedicine health care providers to meet network adequacy standards under ORS 743B.505.
    (d) Require an enrollee to have an established patient-provider relationship with a provider to receive telemedicine health services from the provider or require an enrollee to consent to telemedicine services in person.

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(e) Impose additional certification, location or training requirements for telemedicine providers or restrict the scope of services that may be provided using telemedicine to less than a provider's permissible scope of practice.
(f) Impose more restrictive requirements for telemedicine applications and technologies than those specified in subsection (3) of this section.
(g) Impose on telemedicine health services different annual dollar maximums or prior authorization requirements than the annual dollar maximums and prior authorization requirements imposed on the services if provided in person.
(h) Require a medical assistant or other health professional to be present with an enrollee at the originating site.
(i) Deny an enrollee the choice to receive a health service in person or via telemedicine.
(j) Reimburse an out-of-network provider at a rate for telemedicine health services that is different than the reimbursement paid to the out-of-network provider for health services delivered in person.
(k) Restrict a provider from providing telemedicine services across state lines if the services are within the provider's scope of practice and:
   (A) The provider has an established practice within this state;
   (B) The provider's employer operates health clinics or licensed health care facilities in this state;
   (C) The provider has an established relationship with the patient; or
   (D) The patient was referred to the provider by the patient's primary care or specialty provider located in this state.
(l) Prevent a provider from prescribing, dispensing or administering drugs or medical supplies or otherwise providing treatment recommendations to an enrollee after having performed an appropriate examination of the enrollee in person, through telemedicine or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically.
(m) Establish standards for determining medical necessity for services delivered using telemedicine that are higher than standards for determining medical necessity for services delivered in person.

(6) A health benefit plan and a dental-only plan shall:
   (a) Work with contracted providers to ensure meaningful access to telemedicine services by assessing an enrollee's capacity to use telemedicine technologies that comply with accessibility standards, including alternate formats, and providing the optimal quality of care for the enrollee given the enrollee's capacity;
   (b) Ensure access to auxiliary aids and services to ensure that telemedicine services accommodate the needs of enrollees who have difficulty communicating due to a medical condition, who need an accommodation due to disability or advanced age or who have limited English proficiency;
   (c) Ensure access to telemedicine services for enrollees who have limited English proficiency or who are deaf or hard-of-hearing by providing interpreter services reimbursed at the same rate as interpreter services provided in person; and
   (d) Ensure that telemedicine services are culturally and linguistically appropriate and trauma-informed.

(7) The coverage under subsection (2) of this section is subject to:
   (a) The terms and conditions of the health benefit plan or dental-only plan; and
   (b) Subject to subsection (8) of this section, the reimbursement specified in the contract between the plan and the health professional.

(8) (a) A health benefit plan and dental-only plan must pay the same reimbursement for a health service regardless of whether the service is provided in person or using any permissible telemedicine application or technology.
   (b) Paragraph (a) of this subsection does not prohibit the use of value-based payment methods, including capitated, bundled, risk-based or other value-based payment methods, and does not require that any value-based payment method reimburse telemedicine health services based on an equivalent fee-for-service rate.

9) This section does not require a health benefit plan or dental-only plan to reimburse a health professional:
   (a) For a health service that is not a covered benefit under the plan; [or]
   (b) Who has not contracted with the plan[.]; or
   (c) For a service that is not included within the Healthcare Procedure Coding System or the American Medical Association's Current Procedural Terminology codes or related modifier codes.

(10) This section is exempt from ORS 743A.001.

Section 4. No later than March 1, 2023, the Department of Consumer and Business Services shall report to the interim committees of the Legislative Assembly related to health on the impact of the reimbursement specified in ORS 743A.058 (7) on the cost of health insurance premiums in this state.

Section 5. This 2021 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2021 Act takes effect on its passage.

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743A.185 Telemedical Health Services for Treatment of Diabetes

https://www.oregonlaws.org/ors/743A.185

(1) As used in this section:
   a. "Health benefit plan" has the meaning given that term in ORS 743B.005.
   b. "Originating site" means a location where health services are provided or where the patient is receiving a telemedical health service.
   c. "Telemedical" means delivered through a two-way electronic communication, including but not limited to video, audio, Voice over Internet Protocol or transmission of telemetry, that allows a health professional to interact with a patient, a parent or guardian of a patient or another health professional on a patient's behalf, who is at an originating site.

(2) A health benefit plan must provide coverage of a telemedical health service provided in connection with the treatment of diabetes if:
   a. The plan provides coverage of the health service when provided in person by the health professional;
   b. The health service is medically necessary;
   c. The telemedical health service relates to a specific patient; and
   d. One of the participants in the telemedical health service is a representative of an academic health center.

(3) A health benefit plan may not distinguish between rural and urban originating sites in providing coverage under subsection (2) of this section.

(4) A health benefit plan may subject coverage of a telemedical health service under subsection (2) of this section to all terms and conditions of the plan, including but not limited to deductible, copayment or coinsurance requirements that are applicable to coverage of a comparable health service when provided in person.

(5) This section does not require a health benefit plan to reimburse a provider for a health service that is not a covered benefit under the plan. [2011 c.312 §2]

SB 129 Chapter 234 -Effective 01/01/2020

Section 1.

Section 2 of this 2019 Act is added to and made a part of ORS 683.010 to 683.310

ORS 683.230 Practice of Telemedicine

https://www.oregonlaws.org/ors/683.230

Section 2.

(1) As used in this section:
   (a) "Eye examination" means an assessment of a patient's ocular health and visual status, including but not limited to objective refractive data or information generated by an automated testing device, such as an autorefractor, that is used to establish a medical diagnosis or to determine a refractive error.
   (b) "Optometric clinical health care services" includes, but is not limited to, assessment, consultation, diagnosis, patient education and care management by a licensed optometrist.
   (c) "Store and forward" means the transmission of patient information between a licensed optometrist and a patient, whether or not in real time.
   (d) (A) "Telehealth" means the use of electronic and telecommunications technologies, including remote patient monitoring devices and store and forward technology, to support delivery of optometric clinical health care services.
      (B) "Telehealth" does not include electronic mail communication, facsimile transmission or audio-only telephone communication between a licensed optometrist and a patient, or the use of an automated computer program or managed website to diagnose or treat ocular or refractive conditions.
   (e) "Telemedicine" means the delivery of optometric clinical health care services to a patient by a licensed optometrist through telehealth.

(2) A licensed optometrist may engage in the practice of telemedicine if:
   (a) The licensed optometrist provides notice to the patient that the licensed optometrist intends to practice telemedicine prior to engaging in the practice of telemedicine with the patient;
   (b) The patient is physically located in this state during the practice of telemedicine;
   (c) The technology used in the practice of telemedicine complies with the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and the Health Insurance Portability and Availability Act privacy regulations, 45 C.F.R. parts 160 and 164; and

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(d) The licensed optometrist will provide the patient with an initial prescription for corrective glasses or contact lenses, and the licensed optometrist has an established patient-provider relationship with the patient that includes an in-person eye examination prior to engaging in the practice of telemedicine with the patient.

(3) If the licensed optometrist is employed by or contracts with an entity that operates exclusively through an online platform to provide corrective glasses and contact lenses, the licensed optometrist may engage in the practice of telemedicine with a patient if:
   (a) The practice of telemedicine described in this subsection is not for an initial prescription for corrective glasses or contact lenses; and
   (b) The patient is at least 18 years of age.

(4) The Oregon Board of Optometry may adopt rules related to the practice of telemedicine by licensed optometrists.

Texas

Chapter 1455. Telemedicine and Telehealth

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1455&Phrases=1455.001&HighlightType=1&ExactPhrase=False&QueryText=1455.001

Sec. 1455.001. Definitions

In this chapter:

(1)" Health professional" means:
   (A) A physician;
   (B) An individual who is:
      (i) Licensed or certified in this state to perform health care services; and
      (ii) Authorized to assist a physician in providing telemedicine medical services that are delegated and supervised by the physician; or
   (C) A licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service.

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

(2-a) "Platform" means the technology, system, software, application, modality, or other method through which a health professional remotely interfaces with a patient when providing a health care service or procedure as a telemedicine medical service or telehealth service.

(3) "Telehealth service" and "telemedicine medical service" have the meanings assigned by Section 111.001, Occupations Code.

Sec. 1455.002. Applicability of Chapter

This chapter applies only to a health benefit plan that:

(1) Provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:
   (A) An individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:
      (i) An insurance company;
      (ii) A group hospital service corporation operating under Chapter 842;
      (iii) A fraternal benefit society operating under Chapter 885;
      (iv) A stipulated premium company operating under Chapter 884;
      (v) A health maintenance organization operating under Chapter 843; and
   (B) To the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:
      (i) A multiple employer welfare arrangement as defined by Section 3 of that Act; or
      (ii) Another analogous benefit arrangement; or

(2) Is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Sec. 1455.003. Exception

This chapter does not apply to:

(1) A plan that provides coverage:
   (A) Only for a specified disease;

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(B) Only for accidental death or dismemberment;
(C) For wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or
(D) As a supplement to a liability insurance policy;

(2) A small employer health benefit plan written under Chapter 1501;
(3) A Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
(4) A workers' compensation insurance policy;
(5) Medical payment insurance coverage provided under a motor vehicle insurance policy; or
(6) A long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1455.002.

Sec. 1455.004. Coverage for Telemedicine Medical Services and Telehealth Services

(a) A health benefit plan may not exclude from coverage a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service or a telehealth service on the same basis and to the same extent that the plan provides coverage for the service or procedure in an in-person setting; and
  (2) May not:
    (A) Exclude from coverage a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service or a telehealth service solely because the covered health care service or procedure is not provided through an in-person consultation; and
    (B) Subject to Subsection (c), limit, deny, or reduce coverage for a covered health care service or procedure delivered as a telemedicine medical service or telehealth service based on the health professional's choice of platform for delivering the service or procedure.

(b) A health benefit plan may require a deductible, a copayment, or coinsurance for a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service or a telehealth service. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for the covered health care service or procedure provided through an in-person consultation.

(b-1) Subsection (b) does not authorize a health benefit plan to charge a separate deductible that applies only to a covered health care service or procedure delivered as a telemedicine medical service or telehealth service.

(c) Notwithstanding Subsection (a), a health benefit plan is not required to provide coverage for a telemedicine medical service or a telehealth service provided by only synchronous or asynchronous audio interaction, including:
  (1) An audio-only telephone consultation;
  (2) A text-only e-mail message; or
  (3) A facsimile transmission.

(d) A health benefit plan may not impose an annual or lifetime maximum on coverage for covered health care services or procedures delivered as telemedicine medical services or telehealth services other than the annual or lifetime maximum, if any, that applies in the aggregate to all items and services and procedures covered under the plan.

Sec. 1455.006. Telemedicine Medical Services and Telehealth Services Statement

(a) Each issuer of a health benefit plan shall adopt and display in a conspicuous manner on the health benefit plan issuer's Internet website the issuer's policies and payment practices for telemedicine medical services and telehealth services.

(b) This section does not require an issuer of a health benefit plan to display negotiated contract payment rates for health professionals who contract with the issuer to provide telemedicine medical services or telehealth services.

Texas Health and Safety Code, Chapter 35. Children with Special Care Needs § 35.0041

https://statutes.capitol.texas.gov/Docs/HS/htm/HS.35.htm

Participation and Reimbursement of Telemedicine Medical Service Providers

a) The executive commissioner by rule shall develop and the department shall implement policies permitting reimbursement of a provider for services under the program performed using telemedicine medical services.

b) The policies must provide for reimbursement of:
  1) providers using telemedicine medical services and telehealth services in a cost-effective manner that ensures the availability to a child with special health care needs of services appropriately performed using telemedicine medical

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services and telehealth services that are comparable to the same types of services available to that child without use of telemedicine medical services and telehealth services;

2) a provider for a service performed using telemedicine medical services and telehealth services at an amount equal to the amount paid to a provider for performing the same service without using telemedicine medical services and telehealth services;
3) multiple providers of different services who participate in a single telemedicine medical services or telehealth services session for a child with special health care needs, if the department determines that reimbursing each provider for the session is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without the use of telemedicine medical services and telehealth services, including the costs of transportation and lodging and other direct costs; and
4) providers using telemedicine medical services and telehealth services included in the school health and related services program.

Washington

RCW 48.43.735 Reimbursement of Health Care Services Provided Through Telemedicine or Store and Forward Technology (Effective January 1, 2018) (change in 2020)

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.735
http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5385-S.SL.pdf

1) (a) For health plans issued or renewed on or after January 1, 2017, a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine or store and forward technology if:
    - (i) The plan provides coverage of the health care service when provided in person by the provider;
    - (ii) The health care service is medically necessary;
    - (iii) The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal patient protection and affordable care act in effect on January 1, 2015; and
    - (iv) The health care service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information.

   (b) (i) Except as provided in (b)(ii) of this subsection, for health plans issued or renewed on or after January 1, 2021, a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine at the same rate as if the health care service was provided in person by the provider.
    - (ii) Hospitals, hospital systems, telemedicine companies, and provider groups consisting of eleven or more providers may elect to negotiate a reimbursement rate for telemedicine services that differs from the reimbursement rate for in-person services.
    - (iii) For purposes of this subsection (1)(b), the number of providers in a provider group refers to all providers within the group, regardless of a provider's location.
2) For purposes of this section, reimbursement of store and forward technology is available only for those covered services specified in the negotiated agreement between the health carrier and the health care provider.
3) An originating site for a telemedicine health care service subject to subsection (1) of this section includes a:
    - a) Hospital;
    - b) Rural health clinic;
    - c) Federally qualified health center;
    - d) Physician's or other health care provider's office;
    - e) Community mental health center;
    - f) Skilled nursing facility;
    - g) Home or any location determined by the individual receiving the service; or
    - h) Renal dialysis center, except an independent renal dialysis center.
4) Except for subsection (3)(g) of this section, any originating site under subsection (3) of this section may charge a facility fee for infrastructure and preparation of the patient. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the health carrier. A distant site or any other site not identified in subsection (3) of this section may not charge a facility fee.
5) A health carrier may not distinguish between originating sites that are rural and urban in providing the coverage required in subsection (1) of this section.

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6) A health carrier may subject coverage of a telemedicine or store and forward technology health service under subsection (1) of this section to all terms and conditions of the plan in which the covered person is enrolled including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.
7) This section does not require a health carrier to reimburse:
    a. An originating site for professional fees;
    b. A provider for a health care service that is not a covered benefit under the plan; or
    c. An originating site or health care provider when the site or provider is not a contracted provider under the plan.
8) For purposes of this section:
    a. "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine;
    b. "Health care service" has the same meaning as in RCW 48.43.005;
    c. "Hospital" means a facility licensed under chapter 70.41, 71.12, or 72.23 RCW;
    d. "Originating site" means the physical location of a patient receiving health care services through telemedicine;
    e. "Provider" has the same meaning as in RCW 48.43.005;
    f. "Store and forward technology" means use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email; and
    g. "Telemedicine" means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" does not include the use of audio-only telephone, facsimile, or email.

State Market Plan Enhancements

Oklahoma, Oregon, Texas, and Washington

Refer to the member's Evidence of Coverage (EOC) / Schedule of Benefits (SOB) to determine if Virtual Visits are a selected benefit.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Note: Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine the coverage eligibility.

Telemedicine/Telehealth Services are covered only when all of the following criteria are met:

- Member requires services that are usually provided by direct contact with the provider
- Services are authorized by the member's contracting/participating medical group or UnitedHealthcare
- The healthcare provider has determined Telehealth Services are appropriate
- Provider obtains verbal consent from member to provide Telehealth Services

Refer to the Benefit Interpretation Policy titled Physician Services: Primary Care and Specialist Visits.

Not Covered

Telemedicine/Telehealth Services are not covered when criteria in Section C is not met, unless required by State Mandate.

Definitions

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Telehealth: A health service, other than a Telemedicine, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a Telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- Compressed digital interactive video, audio, or data transmission;
- Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- Other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine: The use of interactive audio, video or other electronic media to deliver health care. This includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. This term does not include services performed using a telephone or facsimile machine.

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
11/01/2021	All	Supporting Information • Archived previous policy version BIP182.I
	Oregon	Federal/State Mandated Regulations • Revised language pertaining to *Oregon Revised Statute Section 743A.058*

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.

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