TELEMEDICINE/TELEHEALTH SERVICES/
VIRTUAL VISITS

Policy Number:  BIP182.G  
Effective Date:  January 1, 2020

Table of Contents  

A. FEDERAL/STATE MANDATED REGULATIONS  
B. STATE MARKET PLAN ENHANCEMENTS  
C. COVERED BENEFITS  
D. NOT COVERED  
E. DEFINITIONS  
F. POLICY HISTORY/REVISION INFORMATION  

Covered benefits are listed in three (3) Sections - A, B and C. 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.

Essential Health Benefits for Individual and Small Group  
For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) 
requires fully insured non-grandfathered individual and small group plans (inside and outside of 
Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large 
group plans (both self-funded and fully insured), and small group ASO plans, are not subject to 
the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage 
for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar 
limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The 
determination of which benefits constitute EHBs is made on a state by state basis. As such, when 
using this guideline, it is important to refer to the member specific benefit document to determine 
benefit coverage.

A. FEDERAL/STATE MANDATED REGULATIONS 

OKLAHOMA  
OAC 435:10-1-4: Definitions.  
"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.
Telemedicine

Physicians treating patients in Oklahoma through telemedicine must be fully licensed to practice medicine in Oklahoma; and

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 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
This act shall be known and may be cited as the “Oklahoma Telemedicine Act”.

§36-6802-Definition of “Telemedicine”
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
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.
OREGON
ORS 743A.058 Telemedical services
1) As used in this section:
   a) "Health benefit plan" has the meaning given that term in ORS 743B.005.
   b) "Health professional" means a person licensed, certified or registered in this state to
      provide health care services or supplies.
   c) "Originating site" means the physical location of the patient.
2) A health benefit plan must provide coverage of a health service that is provided using
   synchronous two-way interactive video conferencing if:
   a) The plan provides coverage of the health service when provided in person by a health
      professional;
   b) The health service is medically necessary;
   c) The health service is determined to be safely and effectively provided using synchronous
      two-way interactive video conferencing according to generally accepted health care
      practices and standards; and
   d) The application and technology used to provide the health service meet all standards
      required by state and federal laws governing the privacy and security of protected health
      information.
3) A health benefit plan may not distinguish between rural and urban originating sites in
   providing coverage under subsection (2) of this section.
4) The coverage under subsection (2) of this section is subject to:
   a) The terms and conditions of the health benefit plan; and
   b) The reimbursement specified in the contract between the plan and the health
      professional.
5) This section does not require a health benefit plan to reimburse a health professional:
   a) For a health service that is not a covered benefit under the plan; or
   b) Who has not contracted with the plan. [2009 c.384 §2; 2015 c.340 §1; 2017 c.309 §5]

ORS 743B.005 Definitions – (16) Health benefit plan
16.  a. "Health benefit plan" means any:
      A. Hospital expense, medical expense or hospital or medical expense policy or
         certificate;
      B. Subscriber contract of a health care service contractor as defined in ORS 750.005;
         or
      C. Plan provided by a multiple employer welfare arrangement or by another benefit
         arrangement defined in the federal Employee Retirement Income Security Act of
         1974, as amended, to the extent that the plan is subject to state regulation.
   b. "Health benefit plan" does not include:
      A. Coverage for accident only, specific disease or condition only, credit or disability
         income;
      B. Coverage of Medicare services pursuant to contracts with the federal government;
      C. Medicare supplement insurance policies;
      D. Coverage of TRICARE services pursuant to contracts with the federal government;
      E. Benefits delivered through a flexible spending arrangement established pursuant to
         section 125 of the Internal Revenue Code of 1986, as amended, when the benefits
         are provided in addition to a group health benefit plan;
      F. Separately offered long term care insurance, including, but not limited to, coverage
         of nursing home care, home health care and community-based care;
      G. Independent, noncoordinated, hospital-only indemnity insurance or other fixed
         indemnity insurance;
      H. Short term health insurance policies that are in effect for periods of 12 months or
         less, including the term of a renewal of the policy;
      I. Dental only coverage;
      J. Vision only coverage;
      K. Stop-loss coverage that meets the requirements of ORS 742.065;
L. Coverage issued as a supplement to liability insurance;
M. Insurance arising out of a workers’ compensation or similar law;
N. Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or
O. Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

743A.185 Telemedical health services for treatment of diabetes.
(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]
(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
(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.

SECTION 3. ORS 683.010 is amended to read:
683.010. As used in ORS 683.010 to 683.310, unless the context requires otherwise:
(1) “Licensed optometrist” means an optometrist licensed under ORS 683.010 to 683.340.
(2) “Optometric nontopical formulary” means the list of nontopical pharmaceutical agents for the treatment of diseases of the human eye and the protocols for their usage adopted by the Council on Optometric Nontopical Formulary under ORS 683.240 (2).
(3) “Practice of optometry” means the use of any means other than invasive or laser surgery, or the prescription of Schedule I and II drugs or pharmaceutical agents that are not on the optometric nontopical formulary, for diagnosis and treatment in the human eye, for the measurement or assistance of the powers or range of human vision or the determination of the accommodative and refractive states of the human eye or the scope of its functions in general or the adaptation of lenses or frames for the aid thereof, subject to the limitations of ORS 683.040. “Practice of optometry” includes the prescription of Schedule II hydrocodone-combination drugs for the purposes listed in this subsection and the use of telemedicine as defined in section 2 of this 2019 Act.
(4) “Trial frames” or “test lenses” means any frame or lens that is used in testing the eye which and that is not sold and not for sale.

SECTION 4. ORS 683.180 is amended to read:
683.180. A person may not:
(1) Sell or barter, or offer to sell or barter, any license issued by the Oregon Board of Optometry.
(2) Purchase or procure by barter any such license with intent to use it as evidence of the holder’s qualification to practice optometry.
(3) Alter the license with fraudulent intent in any material regard.
(4) Use or attempt to use any such license which has been purchased, fraudulently issued, counterfeited or materially altered as a valid license.
(5) Practice optometry under a false or assumed name.
(6) Willfully make any false statement in a material regard in an application for an examination before the board or for a license.
(7) Practice optometry in this state without having at the time of so doing a valid unrevoked license as an optometrist.
(8) Advertise or represent, by displaying a sign or otherwise, to be an optometrist without having at the time of so doing a valid unrevoked license from the board.
(9) Dispense or sell an ophthalmic contact lens without having obtained a valid, unexpired prescription from the person to whom the contact lens is dispensed or sold. As used in this subsection, “ophthalmic contact lens” means a contact lens with or without refractive power, including a plano lens or a cosmetic lens.

Section 5. (1) Section 2 of this 2019 Act and the amendments to ORS 683.010 and 683.180 by sections 3 and 4 of this 2019 Act become operative on January 1, 2020. (2) The Oregon Board of
Optometry may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the board to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the board by section 2 of this 2019 Act and the amendments to ORS 683.010 and 683.180 by sections 3 and 4 of this 2019 Act.

TEXAS:
CHAPTER 1455. TELEMEDICINE AND TELEHEALTH
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;
    (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
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. 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 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)
1) 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:
a) The plan provides coverage of the health care service when provided in person by the provider;
b) The health care service is medically necessary;
c) 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
d) 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.

2) a) If the service is provided through store and forward technology there must be an associated office visit between the covered person and the referring health care provider. Nothing in this section prohibits the use of telemedicine for the associated office visit.
b) For purposes of this section, reimbursement of store and forward technology is available only for those 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 must be subject to a negotiated agreement between the originating site and the health carrier. A distant site or any other site not identified in subsection (3) of this section may not charge a facility fee.

5) A health carrier may not distinguish between originating sites that are rural and urban in providing the coverage required in subsection (1) of this section.

6) A health carrier may subject coverage of a telemedicine or store and forward technology health service under subsection (1) of this section to all terms and conditions of the plan in which the covered person is enrolled including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.

7) This section does not require a health carrier to reimburse:
a. An originating site for professional fees;
b. A provider for a health care service that is not a covered benefit under the plan; or
c. An originating site or health care provider when the site or provider is not a contracted provider under the plan.

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.

B. 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.

C. COVERED BENEFITS

IMPORTANT NOTE: Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered 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:
1. Member requires services that are usually provided by direct contact with the provider
2. Services are authorized by the member's contracting/participating medical group or UnitedHealthcare
3. The healthcare provider has determined Telehealth Services are appropriate
4. Provider obtains verbal consent from member to provide Telehealth Services

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

D. NOT COVERED

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

E. DEFINITIONS

1. 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:
a. compressed digital interactive video, audio, or data transmission;
b. clinical data transmission using computer imaging by way of still-image capture and store and forward; and
c. other technology that facilitates access to health care services or medical specialty expertise.

2. **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.

### F. POLICY HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>State(s) Affected</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2020</td>
<td>All</td>
<td>Supporting Information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Archived previous policy version BIP182.F</td>
</tr>
<tr>
<td></td>
<td>Oregon</td>
<td>Federal/State Mandated Regulations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added language pertaining to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o ORS 683.010</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o ORS 683.180</td>
</tr>
<tr>
<td></td>
<td>Texas</td>
<td>Federal/State Mandated Regulations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Revised language pertaining to <em>Chapter 1455 Telemedicine and Telehealth</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Section 1455.001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Section 1455.004</td>
</tr>
<tr>
<td></td>
<td>Washington</td>
<td>Federal/State Mandated Regulations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed language pertaining to <em>RCW 48.43.735</em></td>
</tr>
</tbody>
</table>