17th Annual Healthcare Law Compliance Symposium: Part I

Thursday, October 8, 2020
3:30 - 5:45 P.M.
Via Zoom
2.0 hours Gen. CLE Credit

Provider #36
The Los Angeles County Bar Association is a State Bar of California approve MCLE provider. The Los Angeles County Bar Association certifies that this activity has been approved for MCLE credit by the State Bar of California.
17th Annual Healthcare Law
Compliance Symposium
Part I

Strategies for Maximizing Efficiency and
Minimizing Liability as Employees Return to the
Workplace During the Pandemic

R. Scott Brink, Jeffer, Mangels, Butler and
Mitchell, LLP

Gregg Fisch, Sheppard Mullin
Strategies For Maximizing Efficiency And Minimizing Liability as Employees Return To The Workplace During the Pandemic

LACBA Healthcare Law Compliance Symposium

October 8, 2020
Strategies For Maximizing Efficiency And Minimizing Liability as Employees Return To The Workplace During the Pandemic

LACBA Healthcare Law Compliance Symposium
October 8, 2020
Unique Employment Law Obligations of Healthcare Providers During the COVID-19 Pandemic

LACBA Healthcare Law Compliance Symposium

October 8, 2020
OBLIGATIONS

1. Keep employees safe
2. Monitor for symptoms
3. Pay for Covid-19 related leave
4. Give notice and bargain with union
OSHA Guidance
OSHA Guidance

- OSHA guidance for keeping healthcare workers safe:
  - Encourage practice of normal hand hygiene and respiratory hygiene
  - Use of PPE when appropriate
  - Appropriate placement of patients with known/suspected COVID
  - Performance of as many tasks as possible in areas away from a patient with suspected or confirmed COVID-19
  - Routine cleaning and disinfection procedures
Cal/OSHA Requirements

- The Aerosol Transmissible Diseases (ATD) standard, which is unique to California, contains requirements for protecting employees from COVID-
the ATD standard applies to Hospitals and other health care facilities

- Hospitals must comply with the ATD standard by implementing the following:
  - Written ATD exposure control plan & procedures
  - Training
  - Engineering controls
  - Work practice controls
  - PPE
  - Respiratory protective equipment
  - Medical services
Notifying Workers of Positive COVID Results

- Cal/OSHA’s ATD standard requires Hospitals to notify employees who have had “significant exposure” to COVID of the date, time and nature of exposure
  - A significant exposure is one in which the circumstances of the exposure make transmission of COVID sufficiently likely that the employee needs further evaluation by a licensed health care practitioner
Employers must report a work-related COVID-19 case to Cal/OSHA where it results in one of the following:

- Death
- Days away from work
- Restricted work or transfer to another job
- Medical treatment beyond first aid
- Loss of consciousness
- Significant injury or illness diagnosed by a physician/other license health care professional
Keeping Employees Away From Work

- Health care workers should not attend work if they have had prolonged close contact with a patient, visitor, or fellow employee, or anyone else, with confirmed COVID-19.

- Health care workers who develop COVID symptoms should not return to work until:
  - At least 10 days have passed since symptoms first appeared and
  - At least 24 hours have passed since last fever without the use of fever-reducing medications and
  - Symptoms have improved
Enforcement?

- Earlier outrage because through May, there had been only a single federal OSHA citation related to COVID-19 (against a Georgia nursing home) despite more than 4,500 coronavirus-related complaints.

- Last check, it does not appear much better.

- Unclear as to California, although we are aware they are sending out complaint letters.
Beginning April 1, 2021, California Hospitals will be required to maintain a stockpile of the following 7 types of personal protective equipment in an amount equal to three months of normal consumption:

1. N95 filtering face-piece respirators
2. Powered air-purifying respirators with high efficiency particulate air filters,
3. Elastomeric air-purifying respirators and appropriate particulate filters or cartridges
4. Surgical masks
5. Isolation gowns
6. Eye protection
7. Shoe coverings
Employee Testing & Monitoring
What Are We Allowed to Do?

- Can you screen employee temperatures/symptoms?
- Can you COVID test?
- Can you antibody test?
- Can you get a waiver?
Employee Testing

- Temperature / symptom screening? OK
- COVID-19 testing? OK
- Antibody testing? Not Yet
- Waivers / releases of liability? NO
Temperature and Symptom Screens

- Protocols:
  - Trained manager taking tests
  - Infrared scanner or other distanced method
  - Self-reporting?

- Wage/hour issues
  - Time spent undergoing screening?
  - Paying for at-home screening?
  - Reporting time pay?

- Recordkeeping
How to Handle Potential Sickness/Exposure?

- Address the sick individual
- Identify the individual’s close contacts (“contact tracing”)
- Notify, but don’t identify
- Quarantine?
- Deep clean/sanitize
- Return to work?
The Big Return to Work Question

- Tested positive for, or are Suspected to have, COVID-19:
  - Pass the time-based strategy:
    - (a) employee with symptoms: at least 1 day (24 hours) have passed since recovery, meaning resolution of fever without use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath), and at least 10 days have passed since symptoms first appeared; or
    - (b) asymptomatic employee with confirmed COVID-19: at least 10 days have passed since the date of the first positive COVID-19 test, assuming no subsequent development of symptoms since the positive test.
  - Test-based strategy:
    - Negative test results from specimens collected more than 24 hours apart (total of two negative specimens) and resolution of symptoms for those who had them.
The Big Return to Work Question cont.

- Contact with a person who is confirmed as positive for COVID-19:
  - Self-quarantine and practice social distancing for 14 days
  - If develop symptoms or otherwise confirmed to have COVID-19, then must follow return-to-work guidelines as above

- Have COVID-19 symptoms:
  - e.g., temperature of 100.4 or higher, chills, moderate to severe sore throat, loss of smell and/or loss of taste, gastrointestinal issues, or other unusual symptoms
  - do NOT come to work.
    - call supervisor as with any other illness situation
    - Recommended to complete a COVID-19 test as soon as possible thereafter and then follow return-to-work guidelines
School Closures

What does this mean for employee scheduling?

Leaves of absence

- FFCRA
- PTO/vacation
- Unpaid LOA
- School attendance leave

Flexible scheduling/teleworking arrangements

Employee surveys to determine staffing/availability
Families First Coronavirus Response Act (FFCRA)
Eligibility for Paid Leave Under FFCRA

• Health care providers are required to provide paid leave to an employee where the employee is unable to work or telework because the employee:

  (1) is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;

  (2) has been advised by a health care provider to self-quarantine related to COVID-19;

  (3) is experiencing COVID-19 symptoms and is seeking a medical diagnosis;

  (4) is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);

  (5) is caring for a child whose school or place of care is closed (or child care provider is unavailable) for reasons related to COVID-19; or

  (6) is experiencing any other substantially-similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury. (Note: the Secretary of Health and Human Services had not specified a substantially similar
An employee is entitled to up to **80 hours** of paid leave when the employee is taking leave for reasons 1-4 on the previous slide:

- Part-time employees are entitled to the number of hours of leave that they work on average over a two-week period.
Duration of Leave under FFCRA

- An employee is entitled to up to **12 weeks** of leave (10 of which must be paid) when the employee is taking leave to care for a child whose school or place of care is closed (or child care provider is unavailable) for reasons related to COVID-19.

- Part-time employees are entitled to up to the number of hours that they are normally scheduled to work over a 12 week period.
Employers are required to pay employees at their regular rate of pay, up to $511 per day and $5,110 in the aggregate (over a two week period) where the employee is taking leave for one of the following reasons:

- (1) employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
- (2) employee has been advised by a health care provider to self-quarantine related to COVID-19;
- (3) employee is experiencing COVID-19 symptoms and is seeking a medical diagnosis
Calculation of Pay

- Employers are required to pay employees at **two-thirds** their regular rate of pay, up to $200 per day and $2,000 in the aggregate where the employee is taking leave to care for an individual who is subject or a quarantine/isolation order or has been advised to self-quarantine by a health care provider.

- Employers are also required to pay employees at **two-thirds** their regular rate of pay, up to $200 per day and $12,000 in the aggregate where the employee is taking leave to care for a child whose school/child care provider is closed due to COVID.
Exemptions under the FFCRA

- Employers may elect to exclude the following from FFCRA coverage:
  - Health Care Providers
  - First Responders
Health Care Provider Exemption

- The Department of Labor regulations currently define “Health Care Provider” to include employees who are directly and indirectly involved in patient care services—doctors, nurses, nurse assistants, medical technicians, and laboratory technicians.
The Department of Labor regulations currently define “Emergency Responders” to include any employee who is necessary for the provision of transport, care, healthcare, comfort and nutrition of patients, or others needed for the response to COVID-19.
Requires health care providers to provide paid sick leave where an employee who is excluded from coverage under the FFCRA is unable to work for one of the following reasons:

- (1) the employee is subject to a federal, state, or local quarantine or isolation order related to COVID-19;
- (2) the employee is advised by a health care provider to self-quarantine or self-isolate due to concerns related to COVID-19; or
- (3) the employee is prohibited from working by the employer due to health concerns related to the potential transmission of COVID-19.
California COVID Paid Leave Law (AB 1867)

- Under the CA paid leave law, employers are required to provide eligible employees with up to 80 hours of leave at the employee’s regular rate of pay, capped at $511 per day and $5,110 in the aggregate.
- Part-time employees are eligible for variable leave amount depending on the hours worked.
Both the FFCRA and California’s COVID paid leave law are set to expire **December 31, 2020**

If the FFCRA is extended, California’s law will be extended to the same date
Hot Topics In Traditional Labor Law: Managing A Union-Represented Workforce in a COVID-19 Environment
AGENDA

Union Issues

The More Things Change The More Things Stay The Same
  - Concerted Protected Activity
  - Making Unilateral Changes
  - Union Access/Information Requests
Concerted Protected Activity

- Action taken by employees for their mutual aid and/or common protection
- The right to band together and act in furtherance of their common interests – must not be just “individual”
- Remember applies to all employees (not just represented ones)
- Work stoppages over COVID-19 health and safety concerns
- Call for hazard pay, workplace inspections, PPE
Unilateral Changes and Employer Flexibility

- General duty to bargain as to wages, hours, working conditions and other terms and conditions of employment
- Maintaining status quo pending bargaining and implementation of time-sensitive workplace changes
- Demonstrating that economic exigencies compelled prompt action (the unforeseen extraordinary event)
- Can you qualify under the Contract Coverage Test?
  - No longer need to meet the “clear and unmistakable waiver” standard
Union Access and Information Requests

- Review your collective bargaining agreement and be pragmatic
- RS Electric Corporation Advice Memo – union access “at any reasonable time”; does not mean “at any time” without restrictions
- Right to enter to inspect – review the health and safety concern
- Determining if the union’s information request is relevant to the union’s duty to represent its members
- Don’t put your books in jeopardy
What’s Next?
What Can We Expect Next?

Employment Lawsuits on the rise:

- Disparate impact from furlough decisions
- LOA denials/failure to accommodate
- Race-based harassment
- Workplace safety (OSHA/Workers’ Comp)
- Wage/Hour class actions
Sheppard Mullin Resources

- Labor and Employment Law Blog: www.laboremploymentlawblog.com

- Coronavirus Insights Page: www.sheppardmullin.com/coronavirus-insights
Thank You for Attending!

Gregg A. Fisch  
Partner, SheppardMullin  
(310) 228-3721  
gfisch@sheppardmullin.com

Scott Brink  
Partner, JMBM  
(310) 785-5365  
rsb@jmbm.com
Telehealth Issues and Opportunities in a COVID World, and Beyond

Adam Romney, Davis Wright Tremaine LLP
Anjali Ahearn, VP and Corporate Counsel, Teladoc
Telehealth Issues and Opportunities in a COVID World, and Beyond

Adam D. Romney, Davis Wright Tremaine
Anjali Ahearn, VP, Corporate Counsel at Teladoc Health
Agenda

1. Growth in Telehealth by the Statistics
2. Federal Law Changes in Telehealth
3. California Law Changes in Telehealth
1. Growth in Telehealth by the Statistics
Telehealth Pre-2020

- Telehealth coverage often limited by patient location
- Low reimbursement, generally
- Lower reimbursement than in-person care
- Unpredictable/ inconsistent coverage, payment, coding rules from commercial payors
- Health system adoption was increasing
  - From 2017 – 2019, health systems offering telehealth rose from 39% to 64%.
- Telehealth industry growth
  - Telehealth industry was expected to grow from $38.3B in 2019 to $130.5B by 2025.
- Low patient adoption
  - In 2019, fewer than 10% of insureds with a telehealth benefit had tried it.
Telehealth Growth after COVID-19

- Increases in patient adoption
- Increases in provider adoption
- States mandating coverage and payment through executive orders/waivers
- States working towards long-term telehealth rules
- Expanded coverage under Medicare and Medicaid
- Technology improvements
- Federal grant programs for broadband access
- Private investment
According to a McKinsey consumer survey conducted in April 2020, Consumer adoption of telehealth has skyrocketed, from 11 percent of US consumers using telehealth in 2019 to 46 percent of consumers now using telehealth to replace cancelled healthcare visits.
Patients with Chronic Disease

- According to doximity, the number of Americans with a chronic illness who reported participating in at least one telehealth visit since the outbreak has increased to 77%.

USE OF TELEHEALTH TO TREAT PATIENTS WITH CHRONIC DISEASE

- Before Pandemic
- After Pandemic
Patients Believe Telemedicine Provides Equal Care

According to doximity, 28% of Americans reported they feel telemedicine is the same or better quality of care when compared to in-person doctor visits, while 53% of those with a chronic illness feel it is the same or better.

These findings align with research published by Penn Medicine, which found 67% of patients surveyed viewed its video and telephone appointments held during the peak of the COVID-19 pandemic as “positive and acceptable substitutes to in-person appointments.”

![Graph comparing telemedicine to in-person visits](image-url)
According to doximity, physicians reporting use of telemedicine doubled from 2019 to 2020.
According to a May 2020 survey of its members, the American Psychiatric Association found that pre-pandemic, 2.1% of respondents reporting engaging in telepsych at least 76-100% of the time. Post pandemic onset, that 2.1% figure jumped to a staggering 84.7%. 

Adoption of Telemedicine in Psychiatry
According to doximity, these are the top 10 specialties using telemedicine.

There is a clear overlap between specialties that are using telemedicine the most and those that manage chronic disease.
Telehealth Adoption by Geography

- Physicians in larger metro areas and east coast states are using telemedicine the most.
- Urban areas are adopting telemedicine most quickly, and the states using telemedicine the least are rural and suburban regions.
- Massachusetts is leading the adoption of telemedicine, followed closely by North Carolina and New Jersey.
Telehealth Market Growth

- Telehealth is expected to account for more than 20 percent of all medical visits conducted in the U.S. in 2020.
- Telemedicine will account for a total of $29B of medical services in 2020.
- In-office visits will account for $106B.
2. Federal Law Changes in Telehealth
Important Medicare Changes – Pre-COVID-19

**Virtual Check-In (G2010; G2012)**
- Synchronous (telephone) or asynchronous (messaging)
- Not billable if derives from or results in another E/M visit

**eConsult (99446-449; 99451-452)**
- Peer-to-peer consult
- Payment to both providers

**eVisit (G2061-2063; 99421-423)**
- Asynchronous online assessment

**Telephone E/M (99441-43)**
- Not billable if it derives from or results in another E/M visit
**Medicare Waivers: Professional Telehealth**

**Patient Location**
- Telehealth services can be provided to patients located in their homes and outside of designated rural areas.

**Telehealth Services Covered**
- CMS significantly expanded the list of services that can be provided via telehealth during the PHE (180 codes).
- Some telehealth services will be covered if provided by telephone.

**Eligible Providers**
- Any professional practitioner who is eligible to bill Medicare for their own services can bill for telehealth

**Supervision**
- Practitioners may supervise services through audio and video, instead of in-person

**Reimbursement**
- Same as if service was provided in-person.
## Medicare Waivers: Hospital Billing for Telehealth

<table>
<thead>
<tr>
<th>Originating Site Fee (Q3014)</th>
<th>Hospital-Based E/M for corresponding professional service (G0463)</th>
<th>Hospital-Based E/M for hospital service (G0463)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hospitals can bill an originating site fee when the patient is at home</td>
<td>• For professional services when the professional is located in the hospital and the patient is registered as a hospital outpatient in their home, which is serving as a provider-based department of the hospital.</td>
<td>• When hospital staff furnish a remote hospital service using telecommunications technology, the hospital may bill a facility claim as if the care was furnished in the hospital.</td>
</tr>
</tbody>
</table>
Medicare Waivers: Other Facility-Based Telehealth

ESRD Facilities
- Monthly face-to-face encounter waived if patients receiving services via telehealth.
- ESRD clinicians not required to have one “hands on” visit per month to monitor vascular access site.

Skilled Nursing Facilities
- Physician and NPP visits for residents can be conducted via telehealth. Face-to-face encounters are not required.

Hospice
- Encounter to determine continued need and eligibility for hospice care can be conducted via telehealth
Medicare Waivers: FQHCs and RHCs

FQHCs and RHCs can provide telehealth services to patients wherever they are located, including in their homes.

The telehealth services can be furnished by any healthcare practitioner working for the FQHC or RHC within their scope of practice.

Practitioners can furnish telehealth services from any distant site location, including their homes, during the times that they are working for the FQHC or RHC.

This includes coverage of certain audio-only telephone E/M services.
Federal Waivers: HIPAA

- The U.S. Dept. of Health & Human Services, Office of Civil Rights (OCR) issued a “Notice of Enforcement Discretion” to allowed providers to use widely available applications for the good faith provision of telehealth services.

- Applications must be “non-public facing” such as:
  - Apple FaceTime
  - Facebook Messenger video chat
  - Google Hangouts Video
  - Zoom
  - Skype
  - WhatsApp
Medicare Advantage and Telehealth (Before Outbreak)

- MA plans must cover the telehealth services available under traditional Medicare
- MA plans must cover services that are adjunct to the delivery of those covered telehealth services (e.g., e-mail, text, etc., between patient and physician)
- MA plans may offer telehealth services as a “supplemental benefit”
  - “Standard” supplemental benefits offered to all enrollees
  - “Targeted” supplemental benefits offered to qualifying enrollees by “objective and measurable” health status or disease state
  - “Chronic” supplemental benefits offered to the chronically ill on an individually tailored basis
Medicare Advantage and Telehealth (Post Outbreak)

- “Special Requirements” during a disaster or emergency
- “Permissive Actions”
  - MA Plans may waive or reduce enrollee cost-sharing for members impacted by the outbreak
  - Such waivers will be deemed to satisfy the Anti-Kickback safe harbor for reduced cost-sharing payments (42 CFR 1001.952(l))
  - “Originating Site” requirements may be waived for telehealth services provided to MA members, should the MA plan “wish”
Drug Enforcement Administration Waivers

- The Drug Enforcement Administration (DEA) has made 2 changes related to prescribing controlled substances during the COVID-19 Public Health Emergency.
- First, qualifying practitioners can prescribe buprenorphine to new and existing patients with opioid use disorder based on a telephone evaluation.

Under normal circumstances, DEA would not consider the initiation of treatment with a controlled substance based on a mere phone call to be consistent with the framework of the CSA given that doing so creates a high risk of diversion. However, in light of the extraordinary circumstances presented by the COVID-19 public health emergency, and being mindful of the exemption issued by SAMHSA, DEA likewise advises that, only for the duration of the public health emergency (unless DEA specifies an earlier date), OTPs should feel free to dispense, and DATA-waived practitioners should feel free to prescribe, buprenorphine to new patients with OUD for maintenance treatment or detoxification treatment following an evaluation via telephone voice calls, without first performing an in-person or telemedicine evaluation. This may only be done, however, if the evaluating practitioner determines that an adequate evaluation of the patient can be accomplished via the use of a telephone. The prescription also must otherwise be consistent with the practitioner’s aforementioned obligation under the CSA and DEA regulations to only prescribe controlled substances for a legitimate medical purpose while acting in the usual course of professional practice.
Drug Enforcement Administration Waivers

- Second, as of March 16, 2020, and continuing for as long as the Secretary’s designation of a public health emergency remains in effect, DEA-registered practitioners in all areas of the United States may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:
  - The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
  - The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and
  - The practitioner is acting in accordance with applicable Federal and State laws.
OIG Guidance: Arrangements Directly Connected to COVID-19

Q: Can a hospital provide access to its existing HIPAA-compliant web-based telehealth platform for free to independent physicians on its medical staff to furnish medically necessary telehealth services during the time period subject to the COVID-19 Declaration?

A: In the unique and exigent circumstances resulting from the COVID-19 outbreak, we believe that free access to a hospital's telehealth platform by physicians on its medical staff would present a low risk of fraud and abuse under the Federal anti-kickback statute and could improve beneficiaries' access to telehealth services, so long as the platform is:

- (i) provided for free to physicians to furnish medically necessary telehealth services;
- (ii) provided only when necessary as a result of the COVID-19 outbreak and during the period subject to the COVID-19 Declaration;
- (iii) not conditioned on the physician's past or anticipated volume or value of referrals to, or other business generated for, the hospital for any items or services that may be reimbursable in whole or in part by a Federal health care program; and
- (iv) offered to all physicians on the medical staff on an equal basis (but not necessarily accepted by every member to whom it is offered).
States Making Telehealth Changes Permanent

- New Hampshire
  - On July 23, 2020, the New Hampshire Governor signed into law H.B. 1623
  - Mandates that the state’s Medicaid program provide coverage and reimbursement parity for telehealth the same as is provided for in person visits.
  - Requires that an insurer offering a health plan in New Hampshire provide coverage and reimbursement telehealth on the same basis as in person.
States Make Telehealth Changes Permanent

- **Colorado**
  - Governor Jared Polis signed SB 212 on July 6, 2020.
  - Requires Colorado State Medicaid program to:
    - reimburse for telehealth services at RHCs and FQHCs at the same rate as for in-person treatment;
    - expands coverage to include speech therapy, physical therapy, occupational therapy, hospice care, home health care, and pediatric behavioral health care; and
    - allows home health care providers to supervise their own telehealth services.
  - Prohibits commercial payers from:
    - requiring an in-person exam before the use of telehealth
    - imposing limitations on location, certification or training as a condition of reimbursement.
    - imposing requirements on the use of HIPAA-compliant technologies to deliver telehealth.
Governors from Washington, Colorado, Nevada and Oregon announced that their states would be working together on telehealth issues. Specifically, they plan to collaborate to identify best practices that would expand telehealth services and benefit each states’ residents. They cite seven principles that will help guide their work together, including:

- Access
- Confidentiality
- Equity
- Standard of Care
- Stewardship
- Patient Choice
- Payment Reimbursement
Medicare Physician Fee Schedule

- August 3, 2020, CMS issued the advance copy of its proposed 2021 Physician Fee Schedule rule (PFS), which contains new telehealth services covered under Medicare. PFS proposes:
  - Removing frequency limitations for facility inpatient-type telehealth services
  - Allowing physicians to fulfill direct supervision requirements while remote, provided the physician is immediately available to engage via audio-video technology
  - Nine new telehealth codes to the list of coverable telehealth services
3. California Law Changes in Telehealth
State Licensing

- Broad provision in Executive Order from March 4, 2020
- Any out-of-state personnel, including, but not limited to, medical personnel, entering California to assist in preparing for, responding to, mitigating the effects of, and recovering from COVID-19 shall be permitted to provide services in the same manner as prescribed in Government Code section 179.5, with respect to licensing and certification.
- Permission for any such individual rendering service is subject to the approval of the Director of the Emergency Medical Services Authority for medical personnel and the Director of the Office of Emergency Services for nonmedical personnel and shall be in effect for a period of time not to exceed the duration of this emergency.
COVID-19 Telehealth Waivers

- Emergency Proclamation (Mar. 4, 2020) and Executive Order N-43-20 (Apr. 3, 2020), provides flexibility in delivery of telehealth services:
  - allows the use of video chats and applications to provide health services without risk of penalty;
  - suspends the requirement that providers obtain and document verbal or written consent before the use of telehealth services; and
  - suspends penalties applied to inadvertent, unauthorized access or disclosure of health information during the good faith of telehealth services
Telehealth & Medi-Cal: Pre-COVID-19

Coverage

• Audio-video, two-way, synchronous services
• Asynchronous store and forward communication

Payment

• The same rate for professional medical services provided by telehealth as it pays for in-person care.

Patients

• Consent required
• Home is an approved ongoing site
Telehealth and Medi-Cal: Post COVID-19

Modality

• Telephone only is covered
• Virtual check-ins are covered
• E-Consults covered

Payment

• Must provide the same amount of reimbursement for a service rendered by telephone or virtual communication as they would if the service is rendered via video.

Family PACT Program

• Telehealth can be used to enroll and recertify people who are eligible for Family PACT family planning services
Temporary Medi-Cal Dental Tele dentistry Flexibilities

- DHCS allows temporary tele dentistry exception for consultation services by telephone or video to be provided to remote Medi-Cal members.
  - CDT code D9430: Used for live streaming video or telephone with a Medi-Cal patient with oral health issues in lieu of an in-person office visit.
  - CDT code D9430 would only be allowed for an actual conversation between the Medi-Cal member and the Medi-Cal provider about oral health issues as their chief complaint.
  - CDT code D9430 should not be billed for conversations with office staff about scheduling or rescheduling appointments.
Medi-Cal Managed Care Plans

- All Medi-Cal Managed Care Plans (MCP) must:
  - Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider’s description of the service on the claim.
  - MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.
- MCPs are responsible for ensuring that their subcontractors and network providers comply.
- MCPs must communicate these requirements to all network providers and subcontractors.
Health Care Service Plan Reimbursement for Telehealth Services

- All health plans must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider’s description of the service on the claim.

- For services provided via telehealth, a health plan may not subject enrollees to cost-sharing greater than the same cost-sharing if the service were provided in person.

- Health plans must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the enrollee.
DMHC: Providers Who May Render Telehealth Services

**Question 3:** Is the option to deliver services via telehealth available for all types of services?

**Answer:** Yes, so long as it is medically appropriate to render the services via telehealth.

During the COVID-19 State of Emergency, a health plan may not exclude coverage of certain types of services or categories of services simply because those services are delivered via telehealth, if the enrollee’s provider, in their professional judgment, determines the services can be effectively delivered via telehealth. For example, a health plan may not categorically exclude coverage for Applied Behavioral Analysis services provided via telehealth (video or telephone) during the State of Emergency.
Question 4: My patient’s health plan says it covers telehealth only when the service is provided by the health plan’s telehealth vendor. Does my patient need to change providers to receive covered services via telehealth?

Answer: No. If you believe, in your professional judgment, that it is medically appropriate for you to provide services to your patient via telehealth and you can effectively provide the services via telehealth, the health plan must cover the services as if you had provided them in-person.

Please note: As stated above in Answer to Question 1, the DMHC’s APL and this FAQ does not apply if your patient receives his/her health care coverage from a self-insured plan, an insurer licensed by the California Department of Insurance, Medicare, Medi-Cal or TRICARE.
California Medical Information Act (CMIA)

- CMIA applies to companies and businesses that contract with providers and plans for work that involves access to medical information. However, the law was recently amended to expand its scope to apply to health app developers, including:
  - “any business that offers software or hardware to consumers, including a mobile application or other related device that is designed to maintain medical information . . . In order to make the information available to an individual or provider of health care for purposes of allowing the individual to manage his or her information, or for the diagnosis, treatment, or management of a medical condition of the individual.”
CMIA Waivers

- In an Executive Order on April 3, 2020, the Governor suspended:
  - administrative fines, civil penalties, and private rights of action under the California Medical Information Act (CMIA) contained in Civil Code sections 56.35 and 56.36 for disclosures made during the good faith provisions of telehealth services;
  - civil penalties contained in Civil Code sections 1798.29 and 1798.82 and related causes of action related to the timely notification to patients of security breaches that occur during the good faith provision of telehealth services;
  - administrative penalties contained in Health and Safety Code sections 1280.15 and 1280.17 and related causes of action related to the unauthorized access or disclosures that occur during the good faith provision of telehealth services; and
  - criminal penalties contained in Welfare and Institutions Code section 14100.2(h) and related causes of action related to the release of information regarding Medi-Cal beneficiaries during the good faith provision of telehealth services.
Concluding Comments

COVID-19 created an urgent need for telehealth

Now, telehealth is here to stay

Now that it’s here, we need:
- Address access disparities
- Protect from cybersecurity concerns

Providers should:
- Integrate telehealth with other care
- Add telehealth to their compliance programs

Medicare needs to catch up
Thank you!

Questions?

Adam D. Romney, Davis Wright Tremaine
Anjali Ahearn, VP, Corporate Counsel at Teladoc Health