

An Update on Telehealth in Texas and Beyond

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Telehealth Initiatives on the Rise in Texas

As published in the [June 2017 issue of Health Law Vitals](#), Texas passed a new law (S.B. 1107) last year that enables healthcare providers to establish a doctor-patient relationship by telehealth—that is, using a telecommunications system without an initial face-to-face meeting. Accordingly, telehealth provider Teladoc voluntarily dismissed its lawsuit against the Texas Medical Board, which revised its rules to conform to the new law. The Texas Health and Human Services Commission is also in the process of amending the Texas Medicaid Telemedicine Services Medical Policy to implement S.B. 1107. The major proposed amendments include:

- Revised definitions of telehealth services and telemedicine medical services;
- Removal of patient site presenter requirements, with an exception for school-based telemedicine medical services;
- Removal of requirements for initial in-person, face-to-face visits between physicians and patients prior to telemedicine medical services; and
- Alignment of telehealth service delivery modalities and operational requirements with those for telemedicine medical services.

Unsurprisingly, the post-S.B. 1107 environment has seen several telehealth initiatives emerge across the state in recent months. We highlight three such initiatives below.

In December, first responders in Harris County, the most populous county in Texas, began a pilot program called Emergency Mobile Psychiatric Assessment via Telehealth (EMPATH). The program arms law enforcement officers with tablets to provide a real-time video connection with psychiatrists available around-the-clock. This allows officers to obtain emergency telepsychiatry evaluations when encountering mental health patients in crisis. The project is a joint effort of the Harris County Sheriff's Office and three companies: Houston-based JSA Health Telepsychiatry, which provides the program's psychiatrists; Cloud 9, an Austin-based startup that developed a mobile app that allows psychiatrists to securely video chat with clients; and Verizon, which provided free use of mobile devices and its cellular network.

In January, Methodist Family Health Centers launched an online diagnosis and treatment service called [Methodist NOW](#). The service provides asynchronous store-and-forward technology. Consumers first fill out an online questionnaire with clinical information. A Methodist physician then reviews the information, communicates with the patient via a real-time chat function, if necessary, and quickly provides a diagnosis and treatment plan. The service is powered by Minneapolis-based telemedicine vendor Zipnosis, which has delivered “virtual care” solutions to nineteen other health systems across the country. Hospitals in other states have similarly partnered with healthcare startups to launch asynchronous store-and-forward services. For example, Cambia Health Solutions in Portland, Oregon, [recently partnered](#) with San Francisco-based Lemonaid Health to help provide employees with online medical advice and prescriptions for common non-acute health

issues.

Finally, the Northwest Texas Healthcare System recently received a federal Distance Learning and Telemedicine (DLT) grant worth \$427,113 to fund the Texas Panhandle Specialty Telemedicine Project—a new telehealth platform that will link the system’s acute care hospital to a network of seven healthcare facilities in the Texas panhandle. The U.S. Department of Agriculture issues DLT grants to finance telehealth projects that seek to improve healthcare access for rural and underserved populations.

Federal Legislative and Regulatory Changes Increasing Telehealth Access

The Bipartisan Budget Act (H.R. 1892) signed into law in February includes key portions from several telehealth bills—namely, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act, Furthering Access to Stroke Telemedicine (FAST) Act, and Increasing Telehealth Access to Medicare Act—that increase access to and reimbursement for telehealth services. For example, the new law allows Accountable Care Organizations to include a patient’s home as an eligible originating site for telehealth services;¹ eliminates geographic restrictions on reimbursement for telestroke consultation services, beginning in 2019; and adds freestanding dialysis facilities, without geographic restriction, to the list of originating sites for patients’ monthly telehealth assessments with a nephrologist, beginning in 2019.

The law also allows Medicare Advantage plans to provide additional telehealth benefits, beginning in 2020. These benefits include benefits that are available under Medicare Part B but are ineligible for payment due to current Medicare restrictions on telehealth and services that are identified as clinically appropriate to furnish using electronic information and telecommunications technology when a physician or practitioner is not at the same location as the patient.

Additionally, the CMS Medicare Physician Fee Schedule final rule for CY 2018 expanded the list of telehealth services that can be reimbursed as “Medicare services” by adding seven new codes:

- HCPCS code G0296 (visit to determine low dose computed tomography (LDCT) eligibility);
- CPT code 90785 (Interactive Complexity);
- CPT codes 96160 and 96161 (Health Risk Assessment);
- HCPCS code G0506 (Care Planning for Chronic Care Management); and
- CPT codes 90839 and 90840 (Psychotherapy for Crisis).

The final rule also decreased providers’ administrative burdens in billing the government for telehealth services by eliminating the required reporting of telehealth modifier GT (via interactive audio and video telecommunications systems) for professional claims. This modifier was deemed redundant since providers are also required to report a place-of-service code describing services furnished via telehealth.

Legislative changes expanding access to care via telemedicine continue to be explored by Congress. For example, the Senate recently passed the bipartisan Veterans E-Health & Telemedicine Support (VETS) Act (S. 925), which expands telehealth services—including mental health treatment—for disabled or rural veterans by allowing Department of Veterans Affairs officials to practice telemedicine across state lines. Additionally, several members of Congress are identifying legislative vehicles to eliminate the restrictions on Medicaid reimbursement for substance abuse treatment to be provided via telehealth and to provide remote patient monitoring.

We will continue to monitor telehealth activities at a state and national level and provide updates.

¹ An “originating site” is the location of an eligible Medicare beneficiary at the time a telehealth service is furnished. The originating sites traditionally authorized by law are physicians’ offices, hospitals (including critical access hospitals), rural health clinics, federally qualified health centers, hospital-based renal dialysis centers, skilled nursing facilities, and community mental health centers. Medicare beneficiaries are eligible for telehealth services only if the originating site is located in a rural Health Professional Shortage Area or in a county outside of a Metropolitan Statistical Area.