

907 KAR 3:170. Telehealth service coverage and reimbursement.

RELATES TO: KRS 194A.060, 194A.125, 205.510(15), 205.559, 205.5591, 205.560, 422.317, 434.840-434.860, 42 C.F.R. 415.174, 415.184, 431.300-431.307, 440.50, 45 C.F.R. 164.530

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.559(2), (7), 205.560

NECESSITY, FUNCTION, AND CONFORMITY: In accordance with KRS 194A.030(2), the Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. KRS 205.559 establishes the requirements regarding Medicaid reimbursement of telehealth providers and KRS 205.559(2) and (7) require the cabinet to promulgate an administrative regulation relating to telehealth services and reimbursement. This administrative regulation establishes the Department for Medicaid Services' coverage and reimbursement policies relating to telehealth services in accordance with KRS 205.559.

Section 1. Definitions. (1) "Asynchronous telehealth" means a store and forward telehealth service that is electronically mediated.

(2) "Department" means the Department for Medicaid Services or its designated agent.

(3) "Face-to-face" means:

(a) In person; and

(b) Not via telehealth.

(4) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(5) "Medical necessity" or "medically necessary" means a covered benefit is determined to be needed in accordance with 907 KAR 3:130 or pursuant to the process established by KRS 304.38-240.

(6) "Place of service" means anywhere the patient is located at the time a telehealth service is provided, and includes telehealth services provided to a patient located at the patient's home or office, or a clinic, school, or workplace.

(7) "Synchronous telehealth" means a telehealth service that simulates a face-to-face encounter via real-time interactive audio and video technology between a telehealth care provider and a Medicaid recipient.

(8) "Telehealth" is defined by KRS 205.510(15).

(9) "Telehealth care provider" means a Medicaid provider who is:

(a) Currently enrolled as a Medicaid provider in accordance with 907 KAR 1:672;

(b) Currently participating as a Medicaid provider in accordance with 907 KAR 1:671;

(c) Operating within the scope of the provider's professional licensure; and

(d) Operating within the provider's scope of practice.

(10) "Telehealth service" means any service that is provided by telehealth and is one (1) of the following:

(a) Event;

(b) Encounter;

(c) Consultation, including a telehealth consultation as defined by KRS 205.510(16);

(d) Visit;

(e) Store and forward transfer, as limited by Section 4 of this administrative regulation;

(f) Remote patient monitoring, as limited by Section 4 of this administrative regulation;

(g) Referral; or

(h) Treatment.

Section 2. General Policies. (1)(a) Except as provided in paragraph (b) of this subsection, the coverage policies established in this administrative regulation shall apply to:

1. Medicaid services for individuals not enrolled in a managed care organization; and
2. A managed care organization's coverage of Medicaid services for individuals enrolled in the managed care organization for the purpose of receiving Medicaid or Kentucky Children's Health Insurance Program services.

(b) A managed care organization shall reimburse the same amount for a telehealth service as the department reimburses unless a different payment rate is negotiated in accordance with Section 3(1)(a)2. of this administrative regulation.

(2) A telehealth service shall not be reimbursed by the department if:

- (a) It is not medically necessary;
- (b) The equivalent service is not covered by the department if provided in a face-to-face setting; or

(c) The telehealth care provider of the telehealth service is:

1. Not currently enrolled in the Medicaid program pursuant to 907 KAR 1:672;
2. Not currently participating in the Medicaid program pursuant to 907 KAR 1:671;
3. Not in good standing with the Medicaid program;
4. Currently listed on the Kentucky DMS Provider Terminated and Excluded Provider List, which is available at <https://chfs.ky.gov/agencies/dms/dpi/pe/Pages/terminated.aspx>; or
5. Currently listed on the United States Department of Health and Human Services, Office of Inspector General List of Excluded Individuals and Entities, which is available at <https://oig.hhs.gov/exclusions/>.

(3)(a) A telehealth service shall be subject to utilization review for:

1. Medical necessity;
2. Compliance with this administrative regulation; and
3. Compliance with applicable state and federal law.

(b) The department shall not reimburse for a telehealth service if the department determines that a telehealth service is not:

1. Medically necessary;
2. Compliant with this administrative regulation;
3. Applicable to this administrative regulation; or
4. Compliant with applicable state or federal law.

(c) The department shall recoup the reimbursement for a previously reimbursed telehealth service if the department determines that a telehealth service was not:

1. Medically necessary;
2. Compliant with this administrative regulation;
3. Applicable to this administrative regulation; or
4. Compliant with applicable state or federal law.

(4) A telehealth service shall have the same referral requirements as a face-to-face service.

(5) Within forty-eight (48) hours of the reconciliation of the record of the telehealth service, a provider shall document within the patient's medical record that a service was provided via telehealth, and follow all documentation requirements established by Section 5 of this administrative regulation.

Section 3. Telehealth Reimbursement. (1)(a)1. The department shall reimburse an eligible telehealth care provider for a telehealth service in an amount that is at least 100 percent of the amount paid for a comparable in-person service.

2. A managed care organization and provider may establish a different rate for telehealth reimbursement via contract as allowed pursuant to KRS 205.5591(5).

(b) A telehealth service reimbursed pursuant to this section shall be subject to cost-sharing pursuant to 907 KAR 1:604.

(2) A provider shall appropriately denote telehealth services by place of service or other means as designated by the department or as required in a managed care organization's contract with the provider or member.

Section 4. Asynchronous Telehealth. (1) An asynchronous telehealth service or store and forward transfer shall be limited to those telehealth services that have an evidence base establishing the service's safety and efficacy.

(2) A store and forward service shall be permissible if the primary purpose of the asynchronous interaction involves high quality digital data transfer, such as digital image transfers. An asynchronous telehealth service within the following specialties or instances of care that meets the criteria established in this section shall be reimbursable as a store and forward telehealth service:

- (a) Radiology;
- (b) Cardiology;
- (c) Oncology;
- (d) Obstetrics and gynecology;
- (e) Ophthalmology and optometry, including a retinal exam;
- (f) Dentistry;
- (g) Nephrology;
- (h) Infectious disease;
- (i) Dermatology;
- (j) Orthopedics;
- (k) Wound care consultation;

(l) A store and forward telehealth service in which a clear digital image is integral and necessary to make a diagnosis or continue a course of treatment;

(m) A speech language pathology service that involves the analysis of a digital image, video, or sound file, such as for a speech language pathology diagnosis or consultation; or

(n) Any code or group of services included as an allowed asynchronous telehealth service pursuant to subsection (4) of this section.

(3) Unless otherwise prohibited by this section, an asynchronous telehealth service shall be reimbursable if that service supports an upcoming synchronous telehealth or face-to-face visit to a provider that is providing one (1) of the specialties or instances of care listed in subsection (2) of this section.

(4)(a) The department shall evaluate available asynchronous telehealth services quarterly, and may clarify that certain asynchronous telehealth services meet the requirements of this section to be included as permissible asynchronous telehealth, as appropriate and as funds are available, if those asynchronous telehealth services have an evidence base establishing the service's:

- 1. Safety; and
- 2. Efficacy.

(b) Any asynchronous service that is determined by the department to meet the criteria established pursuant to this subsection shall be available on the department's Web site.

(5) Except as allowed pursuant to subsection (4) of this section or otherwise within the Medicaid program, a provider shall not receive additional reimbursement for an asynchronous telehealth service if the service is an included or integral part of the billed office visit code or ser-

vice code.

(6)(a) Remote patient monitoring shall not be an eligible telehealth service within the fee-for-service Medicaid program unless that service is:

1. Expanded pursuant to subsection (4) of this section;
2. Otherwise included as a part of a department approved value based payment arrangement; or
3. Otherwise included as a value added service or payment arrangement.

(b) A managed care organization may reimburse for remote patient monitoring as a telehealth service if expanded pursuant to subsection (4) of this section or provided as a:

1. Value based payment arrangement; or
2. Value added service or payment arrangement.

Section 5. Medical Records. (1) A medical record of a telehealth service shall be maintained in compliance with 907 KAR 1:672 and 45 C.F.R. 164.530(j).

(2) A health care provider shall have the capability of generating a hard copy of a medical record of a telehealth service.

Section 6. Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

- (1) Denies federal financial participation for the policy; or
- (2) Disapproves the policy.

Section 7. Appeal Rights. (1) An appeal of a department determination regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.

(2) An appeal of a department determination regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) A provider may appeal a department-written determination as to the application of this administrative regulation in accordance with 907 KAR 1:671.

(4) An appeal of a managed care organization's determination regarding a Medicaid beneficiary shall be in accordance with 907 KAR 17:010. (28 Ky.R. 150; Am. 1430; eff. 12-19-2001; 30 Ky.R. 1861; 2055; eff. 3-18-2004; 32 Ky.R. 1934; 2279; eff. 7-7-2006; 35 Ky.R. 1923; 2456; 2757; eff. 7-6-2009; 39 Ky.R. 1070; 1738; 2036; eff. 5-3-2013; TAm eff. 11-16-2017; 46 Ky.R. 273, 1267, 1423; eff. 12-6-2019.)