State of Tennessee

PUBLIC CHAPTER NO. 4

SECOND EXTRAORDINARY SESSION

HOUSE BILL NO. 2

By Representatives Lamberth, Gant, Smith, Faison, Cameron Sexton, Byrd, Hall, Weaver, White, Sherrell, Rudd, Howell, Hulsey, Jerry Sexton, Griffey, Todd, Garrett, Wright, Grills, Littleton, Moody, Cepicky, Ogles, Haston, Hurt, Kumar, Zachary, Lafferty, Russell, Lynn, Halford, Boyd, Whitson, Vaughan, Rudder, Ramsey, Carr, Moon, Eldridge, Crawford, Keisling, Terry, Travis, Baum, Ragan, Marsh, Helton, Dunn, Hawk, Bricken, Powers, Hazlewood, Sparks, Cochran, Towns, Powell, Hardaway, Doggett, Freeman, Lamar

Substituted for: Senate Bill No. 3

By Senators Johnson, Bailey, Yager, Briggs, Swann, Gardenhire, Reeves, Rose, Yarbro

AN ACT to amend Tennessee Code Annotated, Title 56 and Section 63-1-155, relative to electronic delivery of health care.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-7-1002, is amended by adding the following as a new subsection (h) and redesignating the existing subsection (h) accordingly:

(h) Telehealth is subject to utilization review under the Health Care Service Utilization Review Act, compiled in chapter 6, part 7 of this title.

SECTION 2. Tennessee Code Annotated, Section 56-7-1002(a), is amended by adding the following as a new subdivision:

( ) "Originating site" means the location where a patient is located pursuant to subdivision (a)(6)(A) and that originates a telehealth service to another qualified site;

SECTION 3. Tennessee Code Annotated, Section 56-7-1002(f), is amended by deleting the subsection.

SECTION 4. Tennessee Code Annotated, Section 56-7-1002(h), is amended by deleting the subsection and substituting the following:

(h)

(1) This section does not apply to accident-only, specified disease, hospital indemnity, plans described in § 1251 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended and § 2301 of the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, as amended (both in 42 U.S.C. § 18011), plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1001 et seq.), medicare supplement, disability income, long-term care, or other limited benefit hospital insurance policies.

(2) This section does apply to the basic health plans authorized under title 8, chapter 27, parts 1, 2, 3, and 7.

SECTION 5. Tennessee Code Annotated, Section 56-7-1002, is amended by adding the following as new subsections:

(i) A health insurance entity shall reimburse an originating site hosting a patient as part of a telehealth encounter an originating site fee in accordance with the federal centers for medicare and medicaid services telehealth services rule 42 C.F.R. § 410.78 and at an amount established prior to the effective date of this act by the federal centers for medicare and medicaid services.

(j)

(1) This section does not require a health insurance entity to provide coverage for healthcare services that are not medically necessary, unless the terms and conditions of an applicable health insurance policy provide that coverage.

(2) As used in subdivision (j)(1):

(A) For a healthcare service for which coverage or reimbursement is provided under the Medical Assistance Act of 1968, compiled in title 71, chapter 5, part 1, or provided under title 71, chapter 3, part 11, "medically necessary" means a healthcare service that is determined by the bureau of TennCare to satisfy the medical necessity standard set forth in 71-5-144; and

(B) For all other healthcare services, "medically necessary" means healthcare services that a healthcare services provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease, and that are:

(i) In accordance with generally accepted standards of medical practice;

(ii) Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the patient's illness, injury or disease; and

(iii) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease excluding any costs paid pursuant to subsection (i).

(3) This section does not require a health insurance entity to provide coverage for healthcare services delivered by means of telehealth if the applicable health insurance policy would not provide coverage for the same healthcare services if delivered by in-person means.

(4) This section does not require a health insurance entity to reimburse a healthcare services provider for healthcare services delivered by means of telehealth if the applicable health insurance policy would not reimburse that healthcare services provider if the same healthcare services had been delivered by in-person means.

SECTION 6. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section:

56-7-1003.

(a) As used in this section:

(1) "Health insurance entity" has the same meaning as defined in § 56-7-109 and includes managed care organizations participating in the medical assistance program under title 71, chapter 5;

(2) "Healthcare services" has the same meaning as defined in § 56-61-102;

(3) "Healthcare services provider" means an individual acting within the scope of a valid license issued pursuant to title 63 or title 68, chapter 24, part 6, or any state-contracted crisis service provider employed by a facility licensed under title 33;

(4) "Healthcare system" means two (2) or more healthcare organizations as defined in § 63-1-150, that are affiliated through shared ownership or pursuant to a contractual relationship that controls payment terms and service delivery;

(5) "Practice group" means two (2) or more healthcare services providers that share a common employer for the purposes of the healthcare services providers' clinical practice;

(6) "Provider-based telemedicine":

(A) Means the use of Health Insurance Portability and Accessibility Act (HIPAA) (42 U.S.C. § 1320d et seq.) compliant real-time, interactive audio, video telecommunications, or electronic technology, or store-and-forward telemedicine services, used over the course of an interactive visit by a healthcare services provider to deliver healthcare services to a patient within the scope of practice of the healthcare services provider when:

(i) The healthcare services provider is at a qualified site other than the site where the patient is located and has access to the relevant medical record for that patient;

(ii) The patient is located at a location the patient deems appropriate to receive the healthcare service that is equipped to engage in the telecommunication described in this section; and

(iii) The healthcare services provider makes use of HIPAA compliant real-time, interactive audio, video telecommunications or electronic technology, or store-and-forward telemedicine services to deliver healthcare services to a patient within the scope of practice of the healthcare services provider as long as the healthcare services provider, the healthcare services provider's practice group, or the healthcare system has established a provider-patient relationship by submitting to a health insurance entity evidence of an in-person encounter between the healthcare service provider, the healthcare services provider's practice group, or the healthcare system and the patient within sixteen (16) months prior to the interactive visit; and

(B) Does not include:

(i) An audio-only conversation;

(ii) An electronic mail message or phone text message;

(iii) A facsimile transmission;

(iv) Remote patient monitoring; or

(v) Healthcare services provided pursuant to a contractual relationship between a health insurance entity and an entity that facilitates the delivery of provider-based telemedicine as the substantial portion of the entity's business;

(7) "Qualified site" means the primary or satellite office of a healthcare services provider, a hospital licensed under title 68, a facility recognized as a rural health clinic under federal medicare regulations, a federally qualified health center, a facility licensed under title 33, or any other location deemed acceptable by the health insurance entity; and

(8) "Store-and-forward telemedicine services":

(A) Means the use of asynchronous computer-based communications between a patient and healthcare services provider at a

distant site for the purpose of diagnostic and therapeutic assistance in the care of patients; and

(B) Includes the transferring of medical data from one (1) site to another through the use of a camera or similar device that records or stores an image that is sent or forwarded via telecommunication to another site for consultation.

(b) Healthcare services provided through a provider-based telemedicine encounter must comply with state licensure requirements promulgated by the appropriate licensure boards. Provider-based telemedicine providers are held to the same standard of care as healthcare services providers providing the same healthcare services through in-person encounters.

(c) A provider-based telemedicine provider who seeks to contract with or who has contracted with a health insurance entity to participate in the health insurance entity's network is subject to the same requirements and contractual terms as any other healthcare services provider in the health insurance entity's network.

(d) A health insurance entity:

(1) Shall provide coverage under a health insurance policy or contract for covered healthcare services delivered through provider-based telemedicine;

(2) Shall reimburse a healthcare services provider for a healthcare service covered under an insured patient's health insurance policy or contract that is provided through provider-based telemedicine without any distinction or consideration of the geographic location or any federal, state, or local designation, or classification of the geographic area where the patient is located;

(3) Shall not exclude from coverage a healthcare service solely because it is provided through provider-based telemedicine and is not provided through an in-person encounter between a healthcare services provider and a patient; and

(4) Shall reimburse healthcare services providers who are out-of-network for provider-based telemedicine care services under the same reimbursement policies applicable to other out-of-network healthcare services providers.

(e) A health insurance entity shall provide coverage for healthcare services provided during a provider-based telemedicine encounter in a manner that is consistent with what the health insurance policy or contract provides for in-person encounters for the same service, and shall reimburse for healthcare services provided during a provider-based telemedicine encounter without distinction or consideration of the geographic location, or any federal, state, or local designation or classification of the geographic area where the patient is located.

(f) This section does not require a health insurance entity to pay total reimbursement for a provider-based telemedicine encounter in an amount that exceeds the amount that would be paid for the same service provided by a healthcare services provider for an in-person encounter.

(g)

(1) This section does not require a health insurance entity to provide coverage for healthcare services that are not medically necessary, unless the terms and conditions of an applicable health insurance policy provide that coverage.

(2) As used in subdivision (g)(1):

(A) For a healthcare service for which coverage or reimbursement is provided under the Medical Assistance Act of 1968, compiled in title 71, chapter 5, part 1, or provided under title 71, chapter 3, part 11, "medically necessary" means a healthcare service that is determined by the bureau

of TennCare to satisfy the medical necessity standard set forth in 71-5-144; and

(B) For all other healthcare services, "medically necessary" means healthcare services that a healthcare services provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease, and that are:

(i) In accordance with generally accepted standards of medical practice;

(ii) Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the patient's illness, injury or disease; and

(iii) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

(3) This section does not require a health insurance entity to provide coverage for healthcare services delivered by means of provider-based telemedicine if the applicable health insurance policy would not provide coverage for the same healthcare services if delivered by in-person means.

(4) This section does not require a health insurance entity to reimburse a healthcare services provider for healthcare services delivered by means of provider-based telemedicine if the applicable health insurance policy would not reimburse that healthcare services provider if the same healthcare services had been delivered by in-person means.

(h) Any provisions not required by this section are governed by the terms and conditions of the health insurance policy or contract.

(i) Provider-based telemedicine is subject to utilization review under the Health Care Service Utilization Review Act, compiled in chapter 6, part 7 of this title.

(j)

(1) This section does not apply to accident-only, specified disease, hospital indemnity, plans described in § 1251 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended and § 2301 of the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, as amended (both in 42 U.S.C. § 18011), plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1001 et seq.), medicare supplement, disability income, long-term care, or other limited benefit hospital insurance policies.

(2) This section does apply to the basic health plans authorized under title 8, chapter 27, parts 1, 2, 3, and 7.

SECTION 7. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section:

(a) As used in this section, "remote patient monitoring services" means using digital technologies to collect medical and other forms of health data from a patient and then electronically transmitting that information securely to healthcare providers in a different location for interpretation and recommendation.

(b) A health insurance entity may consider any remote patient monitoring service a covered medical service if the same service is covered by medicare. The appropriate parties may negotiate the rate for these services in the manner in which is deemed appropriate by the parties.

(c) Reimbursement of expenses for covered remote patient monitoring services must be established through negotiations conducted by the health insurance entity with the healthcare services provider, healthcare system, or practice group in the same manner as the health insurance entity establishes reimbursement of expenses for covered healthcare services that are delivered by in-person means.

(d) Remote patient monitoring services are subject to utilization review under the Health Care Service Utilization Review Act, compiled in chapter 6, part 7 of this title.

(e) This section does not apply to a health incentive program operated by a health insurance entity that utilized an electronic device for physiological monitoring.

SECTION 8. Tennessee Code Annotated, Title 56, Chapter, 7, Part 10, is amended by adding the following as a new section:

(a) Notwithstanding § 56-7-1002(e), a health insurance entity shall provide reimbursement for healthcare services provided during a telehealth encounter in a manner that is consistent with what the health insurance policy or contract provides for in-person encounters for the same service, and shall reimburse for healthcare services provided during a telehealth encounter without distinction or consideration of the geographic location, or any federal, state, or local designation or classification of the geographic area where the patient is located.

(b) Notwithstanding § 56-7-1003(e), a health insurance entity shall provide reimbursement for healthcare services provided during a provider-based telemedicine encounter in a manner that is consistent with what the health insurance policy or contract provides for in-person encounters for the same service, and shall reimburse for healthcare services provided during a provider-based telemedicine encounter without distinction or consideration of the geographic location, or any federal, state, or local designation or classification of the geographic area where the patient is located.

(c) Reimbursement made pursuant to this section is subject to utilization review under the Health Care Service Utilization Review Act, compiled in title 56, chapter 6, part 7.

(d)

(1) This section does not require a health insurance entity to provide reimbursement for healthcare services that are not medically necessary, unless the terms and conditions of an applicable health insurance policy provide that coverage.

(2) As used in this subsection (d):

(A) For a healthcare service for which coverage or reimbursement is provided under the Medical Assistance Act of 1968, compiled in title 71, chapter 5, part 1, or provided under title 71, chapter 3, part 11, "medically necessary" means a healthcare service that is determined by the bureau of TennCare to satisfy the medical necessity standard set forth in 71-5-144; and

(B) For all other healthcare services, "medically necessary" means healthcare services that a healthcare services provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease, and that are:

(i) In accordance with generally accepted standards of medical practice;

(ii) Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the patient's illness, injury or disease; and

(iii) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

(e) This section does not require a healthcare services provider to seek reimbursement from a health insurance entity for healthcare services provided by telehealth or provider-based telemedicine.

(f) For the purposes of this section:

(1) "Health insurance entity" has the same meaning as defined in § 56-7-109 and includes managed care organizations participating in the medical assistance program under title 71, chapter 5;

(2) "Healthcare services" has the same meaning as defined in § 56-61-102;

(3) "Healthcare services provider" means an individual acting within the scope of a valid license issued pursuant to title 63 or title 68, chapter 24, part 6, or any state-contracted crisis service provider employed by a facility licensed under title 33;

(4) "Provider-based telemedicine" has the same meaning as defined in § 56-7-1003; and

(5) "Telehealth" has the same meaning as defined in § 56-7-1002.

(g) This section is repealed on April 1, 2022.

SECTION 9. Tennessee Code Annotated, Section 63-1-155, is amended by deleting the section and substituting instead the following:

(a) For the purposes of this section:

(1) "Healthcare provider" means:

(A) An individual acting within the scope of a valid license issued pursuant to this title;

(B) Any state-contracted crisis service provider that is employed by a facility licensed under title 33; or

(C) Any alcohol and drug abuse counselor licensed under title 68, chapter 24, part 6; and

(2) Notwithstanding any restriction imposed by §§ 56-7-1002 and 56-7-1003, "telehealth," "telemedicine," and "provider-based telemedicine" mean the use of real time audio, video, or other electronic media and telecommunication technology that enables interaction between a healthcare provider and a patient, or also store-and-forward telemedicine services as defined in § 56-7-1002, for the purpose of diagnosis, consultation, or treatment of a patient at a distant site where there may be no in-person exchange between a healthcare provider and a patient.

(b) For the purposes of this section, a healthcare provider-patient relationship with respect to telemedicine or telehealth is created by mutual consent and mutual communication, except in an emergency, between the patient and the provider. The consent by the patient may be expressed or implied consent; however, the provider-patient relationship is not created simply by the receipt of patient health information by a provider unless a prior provider-patient relationship exists. The duties and obligations created by the relationship do not arise until the healthcare provider:

(1) Affirmatively undertakes to diagnose or treat the patient; or

(2) Affirmatively participates in the diagnosis or treatment.

(c)

(1)

(A) A healthcare provider who delivers services through the use of telehealth is held to the same standard of professional practice as a similar licensee of the same practice area or specialty that is providing the same healthcare services through in-person encounters, and nothing in this section is intended to create any new standards of care.

(B) Notwithstanding subdivision (c)(1)(A), telehealth services must be provided in compliance with the guidelines created pursuant to part 4 of this chapter.

(2) The board or licensing entity governing any healthcare provider covered by this section shall not establish a more restrictive standard of professional practice for the practice of telehealth than that specifically authorized by the provider's practice act or other specifically applicable statute, including this chapter or title 53, chapter 10 or 11.

(3) This section does not apply to pain management clinics, as defined in § 63-1-301, chronic nonmalignant pain treatment, or those individuals licensed pursuant to chapter 12 of this title.

(d) Section 63-6-231 and subdivision 63-6-214(b)(21) do not apply to the practice of telemedicine under this section.

(e) This section does not apply to or restrict the requirements of § 63-6-241.

(f) Section 63-6-204(a) also applies to telemedicine.

(g)

(1) Except as provided in subdivision (g)(2), to practice under this section a healthcare provider must be licensed to practice in this state under this title.

(2) A physician must be licensed to practice under chapter 6 or 9 of this title in order to practice telemedicine pursuant to § 63-6-209(b), except as otherwise authorized by law or rule.

(h)

(1) Notwithstanding subsection (a), for the purposes of this section "healthcare provider" means:

(A) Any provider licensed under this title;

(B) Any state-contracted crisis service provider that is employed by a facility licensed under title 33; or

(C) Any alcohol and drug abuse counselor licensed under title 68, chapter 24, part 6.

(2) This subsection (h) is repealed on April 1, 2022.

SECTION 10. This act shall take effect upon becoming a law, the public welfare requiring it, and applies to insurance policies or contracts issued, entered into, renewed, or amended on or after the effective date of this act.

SECOND EXTRAORDINARY SESSION

HOUSE BILL NO. 2

PASSED: August 12, 2020

CAMERON SEXTON, SPEAKER
HOUSE OF REPRESENTATIVES

RANDY MCNALLY
SPEAKER OF THE SENATE

APPROVED this 20th day of August 2020

BILL LEE, GOVERNOR