

WAC 284-170-433 Provider contracts—Telemedicine. (1)(a) Every participating provider contract must, for health plans issued or renewed on or after January 1, 2017, provide that 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:

(i) The plan provides coverage of the health care service when provided in person by the provider;

(ii) The health care service is medically necessary;

(iii) 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, RCW 48.43.005 and 48.43.715;

(iv) 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; and

(b) Beginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider.

(2)(a) Every participating provider contract must, for health plans issued or renewed on or after January 1, 2021, provide that, except as provided in (b) of this subsection, a carrier will reimburse a provider for a health care service provided to a covered person through telemedicine as provided in RCW 48.43.735(1) or subsection (1) of this section the same amount of compensation the carrier would pay the provider if the health care service was provided in person by the provider.

(b) Hospitals, hospital systems, telemedicine companies, and provider groups consisting of 11 or more providers may elect to negotiate an amount of compensation for telemedicine services that differs from the amount of compensation for in-person services.

For purposes of (b) of this subsection, the number of providers in a provider group refers to all providers within the group, regardless of a provider's location.

(c) 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)(a) Every participating provider contract must, for health plans issued or renewed on or after January 1, 2017, provide that an originating site for a telemedicine health care service subject to subsection (1) of this section includes a:

(i) Hospital;

(ii) Rural health clinic;

(iii) Federally qualified health center;

(iv) Physician's or other provider's office;

(v) Licensed or certified behavioral health agency;

(vi) Skilled nursing facility;

(vii) Home or any location determined by the individual receiving the service including, but not limited to, a pharmacy licensed under chapter 18.64 RCW or a school-based health center as defined in RCW 43.70.825. If the site chosen by the individual receiving service is in a state other than the state of Washington, a provider's ability to conduct a telemedicine encounter in that state is determined by the

licensure status of the provider and the provider licensure laws of the other state; or

(viii) Renal dialysis center, except an independent renal dialysis center.

(b) Except for (a)(vii) of this subsection and a hospital that is an originating site for an audio-only telemedicine encounter, any originating site under this subsection may charge a facility fee for infrastructure and preparation of the patient. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the health carrier. A distant site, a hospital that is an originating site for an audio-only telemedicine encounter, or any other site not identified in this subsection may not charge a facility fee.

(4) 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.

(5) 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.

(6)(a) Every participating provider contract must, effective July 25, 2021, provide that if a provider intends to bill a covered person or the covered person's health plan for an audio-only telemedicine service, the provider must obtain patient consent from the covered person for the billing in advance of the service being delivered, consistent with the requirements of this subsection and state and federal laws applicable to obtaining patient consent.

(b)(i) A covered person's consent must be obtained prior to initiation of the first audio-only encounter with a provider and may constitute consent to such encounters for a period of up to 12 months. If audio-only encounters continue beyond an initial 12-month period, consent must be obtained from the covered person for each prospective 12-month period.

(ii) Consent to be billed for audio-only telemedicine services must be obtained by the provider or auxiliary personnel under the general supervision of the provider.

(iii) A covered person may consent to a provider billing them or their health plan in writing or verbally. Consent to billing for an audio-only telemedicine encounter may be obtained and documented by the provider or auxiliary personnel under the general supervision of the provider as part of the process of making an appointment for an audio-only telemedicine encounter, recorded verbally as part of the audio-only telemedicine encounter record or otherwise documented in the patient record. Consent must be documented and retained by the provider for a minimum of five years. As needed, a carrier also may request documentation of the covered person's consent as a condition of claim payment.

(iv) A patient may revoke consent granted under this subsection. Revocation of the patient's consent must be communicated by the patient or their authorized representative to the provider or auxiliary personnel under the general supervision of the provider verbally or in writing and must be documented and retained by the provider for a minimum of five years. Once consent is revoked, the revocation must operate prospectively.

(7) (a) A carrier may not deny, reduce, terminate or fail to make payment for the delivery of health care services using audio and visual technology solely because the communication between the patient and provider during the encounter shifted to audio-only due to unanticipated circumstances. In these instances, a carrier may not require a provider to obtain consent from the patient to continue the communication.

(b) A carrier has no obligation to reimburse a provider for both an audio-visual and an audio-only encounter when both means of communication have been used during the encounter due to unforeseen circumstances.

(8) (a) If the commissioner has cause to believe that any provider has engaged in a pattern of unresolved violations of RCW 48.43.735(8) or subsection (6) of this section, the commissioner may submit information to the department of health or the appropriate disciplining authority, as defined in RCW 18.130.020, for action.

(b) In determining whether there is cause to believe that a provider has engaged in a pattern of unresolved violations, the commissioner shall consider, but is not limited to, consideration of the following:

(i) Whether there is cause to believe that the provider has committed two or more violations of RCW 48.43.735(8) or subsection (6) of this section;

(ii) Whether the provider has been nonresponsive to questions or requests for information from the commissioner related to one or more complaints alleging a violation of RCW 48.43.735(8) or subsection (6) of this section; and

(iii) Whether, subsequent to correction of previous violations, additional violations have occurred.

(c) Prior to submitting information to the department of health or the appropriate disciplining authority, the commissioner may give the provider an opportunity to cure the alleged violations or explain why the actions in question did not violate RCW 48.43.735(8) or subsection (6) of this section.

(9) Every participating provider contract must, for health plans issued or renewed on or after July 25, 2021, ensure that access to telemedicine services is inclusive for those patients who may have disabilities or limited-English proficiency and for whom the use of telemedicine technology may be more challenging, consistent with carriers' obligations under WAC 284-43-5940 through 284-43-5965 with respect to design and implementation of plan benefits.

(10) Each carrier's provider contracts must include language conforming to the requirements of this section by July 1, 2022. The grace period associated with carriers filing conforming changes to their provider contracts under this section in no way limits the authority of the commissioner to enforce the provisions of RCW 48.43.735 or this section on or after the effective date of those laws.

(11) 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 provider when the site or provider is not a participating provider under the plan.

[Statutory Authority: RCW 48.43.735(9). WSR 21-24-029, § 284-170-433, filed 11/22/21, effective 12/23/21.]