Nebraska pays for telepsychiatry + a separate transmission fee ($.08/minute).

Nebraska Telehealth Statutes 2014

Legislative Bill 1076 enacted in 2014 allows Medicaid payment for telehealth when patient is at home.

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES TITLE 471

NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES (See page 17)

1-006 TELEHEALTH SERVICES

1-006.01 Scope and Authority: These regulations govern Medicaid covered telehealth services and implement the Nebraska Telehealth Act (Neb. Rev. Stat. Sections 71-8501 to 8508). This statute authorizes the Department to cover telehealth consultations and transmission costs.
Under the Act telehealth consultation means any contact between a patient and a health care practitioner relating to the health care diagnosis or treatment of such patient through telehealth but does not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a patient or a consultation between two health care practitioners. "Consultation" elsewhere in the Nebraska Medical Assistance Program (NMAP) regulations refers to services provided by a physician specialist. Therefore, for purposes of these NMAP regulations, "telehealth service" is used instead of "telehealth consultation" to clarify that coverage is available beyond the traditional meaning of "consultation".

Medicaid coverage for telehealth services allows clients, particularly those in medically underserved areas of the state, to improve access to essential health care services that may not otherwise be available without traveling long distances.

1-006.02 Definitions:

Electronic Mail (e-mail) Transmission means transactions of a text or graphical nature between two or more persons exchanged by e-mail over public or private data communications networks including the Internet.

Facsimile Transmission means transactions of a text or graphical nature between two or more persons exchanged via facsimile (FAX) over the Public Switched Telephone Network (PSTN) or other public or private data communications networks including the Internet.

FDA means the federal Food and Drug Administration.

H.320 means the industry-wide compressed audiovideo communication standard from the International Telecommunications Union (ITU) for real time, two-way interactive audiovideo
transmission with a minimum signal of 384 kbps (kilobits per second) over a dedicated line; this may include a switched connection.

H.323 means the industry-wide compressed audiovideo communication standard from the International Telecommunications Union (ITU) for real time, two-way interactive audiovideo transmission with a minimum signal of 384 kbps (kilobits per second) over an intranet or other controlled environment system.

Health Care Practitioner means a health care professional who is licensed, certified, or registered with Nebraska Department of Health and Human Services Regulation and Licensure or with the comparable agency in the state in which s/he practices his/her profession.

Health Care Practitioner Facility means the residence, office, or clinic or a practitioner or group of practitioners who are enrolled with Medicaid and credentialed under the Uniform Licensing Law or any distinct part of such residence, office, or clinic.

Legally Authorized Representative means the client's parent if the client is a minor child, a legal guardian, or a person with power of attorney for the client.

T1 Line means a digital transmission service of 1.544 Mbps.

Telehealth means the use of telecommunications technology by a health care practitioner to deliver health care services within his or her scope of practice to a patient located at a site other than the site where the practitioner is located.

Telehealth Service means any contact between a patient and a health care practitioner relating to the health care diagnosis or treatment of such patient through telehealth but does not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a patient or a consultation between two health care practitioners.
Telehealth Site means either a health care facility enrolled with Medicaid and licensed under Neb. Rev. Stat. Section 71-2017 to 71-2029, and effective January 1, 2001, licensed under the Health Care Facility Act or a health care practitioner facility whose practitioners are enrolled with Medicaid and credentialed under the Uniform Licensing Law.

Telephone Conversation means a transaction conducted by voice conversations between two or more persons over a private telecommunication system or the Public Switched Telephone Network (PSTN).

Telephone means an instrument for reproducing sounds at a distance; specifically, one in which sound is converted into analog or digital signals for transmission by wire or other modality.

Transmission Cost means the cost of the line charge incurred during the time of the transmission of a telehealth service.

USF means the Universal Services Fund established under the federal Telecommunications Act of 1996.

1-006.03 Standards for Provider Participation:

Health care practitioners must:

1. Act within their scope of practice;

2. Be enrolled with NMAP; and

3. Be appropriately licensed, certified, or registered by the Nebraska HHS Regulation and Licensure agency for the service for which they bill Medicaid. (An exception to this requirement...
may be allowed when the telehealth service is delivered out-of-state and covered under 471 NAC 1-006.10D Out of State Services.)

Entities enrolled as Medicaid providers other than practitioners (such as hospitals) which bill for practitioner services may bill for telehealth services when the practitioner providing the service meets the above requirements.

In providing telehealth services, health care practitioners and health care facilities shall follow all applicable state and federal laws and regulations governing their practice, including, but not limited to, the requirements for maintaining confidentiality and obtaining informed consent.

Prior to billing Medicaid for any telehealth services, each telehealth site must submit a letter (2 copies) to the Department as required under 471 NAC 1-006.10C regarding quality assurance issues.

1-006.04 Coverage for Telehealth Services and Transmission Costs: Effective July 1, 2000, Medicaid services that are otherwise covered in the NMAP and are provided via telecommunication technologies may be reimbursed under the conditions and limitations set forth in these regulations. Payment for telehealth services must be consistent with the federal requirements of efficiency, economy, and quality. In-person contact between a health care provider and a client is not required under the NMAP telehealth regulations except where otherwise required by federal statute or regulation.

Services otherwise covered by NMAP and delivered via telecommunications technology may be reimbursed when the following conditions are met:

1-006.04A Health Care Practitioner Requirement: Telehealth services are covered only when provided by a health care practitioner meeting the requirements in 471 NAC 1-006.03 Standards for Provider Participation.
1-006.04B NMAP 471 and 482 NAC Requirements: Services provided via telehealth are subject to all current NMAP regulations in 471 and 482 NAC including, but not limited to, the requirement:

1) that services are medically necessary and appropriate to the client’s condition;

2) that active treatment for mental health/substance abuse services is met; and

3) that the service provided is a generally accepted standard of care.

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MANUAL LETTER # 59-2003 AND SUPPORT MANUAL 471 NAC 1-006.04C

1-006.04C Telecommunications Technology: Coverage is only available for telehealth services and for telehealth transmission costs when, at a minimum, the H.320 or H.323 audiovideo standards for real time, two-way interactive audiovisual transmission are met or when any analog or alternate transmission technology system equals or exceeds the H.320 or H.323 standard for clarity and quality. The Department may request an independent expert opinion as to whether a provider’s system meets the technology standards for this requirement.

In addition, the telecommunication technology and equipment used at the client site and at the practitioner site must be sufficient to allow the health care practitioner to appropriately evaluate, diagnose, or treat the client or to appropriately accomplish the service billed to Medicaid. At a minimum, the equipment must be of a level of quality to accomplish the level of service and to adequately complete all necessary components as defined in the national standard code sets billed to NMAP.
If a peripheral diagnostic scope or device is required to assess the client, it must provide adequate resolution or audio quality for decision making via telehealth.

Coverage is available for teleradiology services when these services meet the American College of Radiology standards for teleradiology (see ACR Standard for Teleradiology: Revised 1998 (Res.35) Effective 1/1/99 as amended – attached and incorporated by reference).

1-006.04D Prior Authorization: All prior authorization requirements outlined in 471 and 482 NAC for specific services must be met to be covered as a telehealth service. Prior authorization requests must state the intent to provide the service as a telehealth service.

1-006.04E Transmission Costs: Transmission costs for line charges are allowable when directly related to a covered telehealth service and when the standards in 1-006.04C are met for real time, two-way interactive audio visual transmission.

Transmission costs may be covered as outlined in these regulations. However, transmission costs are not a separate billable service and are included in the payment for inpatient hospital services or in the per diem or per monthly payment for the other services below:

1. Inpatient Hospital Services, including general hospital as well as psychiatric and rehabilitation hospital services;

2. Nursing Facility Services;

3. Intermediate Care Facility-Mentally Retarded (ICF-MR) Services;

4. Assisted Living Facility Services;
5. Residential Treatment Center Services;

6. Treatment Group Home Services;

7. Day Treatment Facility Services;

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8. Treatment Foster Care Services;

9. Mental Health/Substance Abuse Crisis Facility Services; and


When a client receives a telehealth service as part of the services listed above, the transmission service must be reported on each individual claim and on the facility’s cost report.

1-006.04F Managed Care: Coverage of services delivered via telecommunications technology under contracted Medicaid managed care plans is required to the extent that coverage and reimbursement is available under the Medicaid fee-for-service program. In the event that coverage of services delivered through telehealth proves not to be cost neutral, the appropriate capitation rates may be adjusted.

No fee-for-service coverage outside the managed care plan is available for telehealth services.
for clients enrolled in managed care.

All managed care referral procedures and authorization requirements shall be followed (see Title 482 NAC).

1-006.05 Non-Covered Telehealth Services: Services provided via telehealth technologies are not covered when any one of the following conditions is met:

1-006.05A Non-Covered Medicaid Services: Services not otherwise covered by Nebraska Medicaid are not covered when delivered via telehealth.

1-006.05B Services Excluded from Coverage as a Telehealth Service: Services covered under other Medicaid regulations but specifically excluded from telehealth coverage are:

1. Medical Equipment and Supplies provided by DME (Durable Medical Equipment) suppliers and pharmacies;

2. Orthotics and Prosthetics provided by DME suppliers and pharmacies;

3. Personal care aide (PCA) services;

4. Home Health Aide Services;

5. Pharmacy services for prescribed drugs;
6. Home and Community Based Waiver services provided by persons who do not meet the standards for a practitioner of telehealth services in 471 NAC 1-006.03;

7. Mental Health, Substance Abuse, and Psychiatric Rehabilitation services provided by persons who do not meet the standards for a practitioner of telehealth services in 471 NAC 1-006.03 (e.g., Community Treatment Aids; Certified Alcohol and Drug Abuse Counselors; Ph. D. candidates who are not licensed or certified; and other enrolled professionals who are not licensed, certified, or registered by HHS – Regulation and Licensure);

8. Medical Transportation services, including ambulance services;

9. Federal Qualified Health Center core services billed as an "encounter" service;

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10. Rural Health Clinic core services billed as an "encounter" service;

11. Physician visits to clients in nursing facilities required on the specified periodic schedule for nursing facility certification;

12. Tribal 638 Clinic core services billed as an "encounter" service;

13. Services requiring "hands on" professional services such as eye glass fittings and hearing aid fittings;
14. Services provided in public schools by staff who are not licensed, certified, or registered with HHS – Regulation and Licensure;

15. Ambulatory Room and Board services; and

16. Other services that do not meet the requirements of these telehealth regulations.

1-006.05C Inappropriate Telecommunications Technologies: Coverage is not available when the minimum standards for telecommunication technologies in 471 NAC 1-006.04C are not met or when the technologies used are not appropriate for the service delivered and billed to Medicaid.

1-006.D Free to the General Public: Medicaid does not reimburse services that are provided free to the general public. See 471 NAC 3-001.02D and 2-001.03(1 through 5).

1-006.05E Distance Requirement: Services provided via telecommunications technologies are not covered if the client has access to a comparable service within 30 miles of his/her place of residence. This requirement does not apply:

1. In emergency or urgent medical situations;

2. When accessing the appropriate service at a distance less than 30 miles poses a significant hardship on the client due to a medical condition or disability; or

3. To clients residing in nursing facilities who require transportation to the appropriate service via ambulance.
When billing a telehealth service or transmission cost within a 30 mile radius of the client’s place of residence, one of the above three reasons must be documented in the medical record and available to the Department upon request.

1-006.05F E-Mail, Telephone, and Facsimile Transmissions: Telehealth services provided via e-mail, telephone, or facsimile transmissions are not covered.

1-006.05G Devices Subject to FDA Approval: Medicaid does not cover services that utilize a device or telecommunication technology subject to FDA approval but not FDA approved for the telehealth service. However, FDA approval does not guarantee coverage of a service.

1-006.05H Prescriptions over the Internet: Neither the prescribing health care practitioner service nor the pharmacy service is covered when the health care practitioner prescribing the medication has only reviewed an e-mail message or e-mail questionnaire about the client.

1-006.05I Investigational/Experimental Services: A telehealth service is not covered when the service delivered via telecommunication technology is deemed to be investigational or experimental under 471 NAC 1-002.02C. Even though a service is covered when provided in-person to a client, the service may be deemed investigational/experimental for Medicaid payment purposes when provided via telecommunications technology. (Also, see 471 NAC 1-006.05G regarding devices requiring FDA approval.)

An example of a service excluded from telehealth coverage because the services are deemed investigational/experimental or do not meet current accepted standards of medical care is as follows: surgery performed by a mechanical device operated by a practitioner who is at a site different from where the patient is located.
1-006.05J Services Requiring Direct Physical Contact with a Practitioner: Services that require
direct physical contact with a client by a health care practitioner and that cannot be delegated to
another health care practitioner at the site where the client is located are not covered.

1-006.06 Non-Covered Transmission Costs

1-006.06A Low Transmission Capacity: Transmission costs are not covered when the real time,
two-way interactive audio-visual transmission is below the standards stated in 471 NAC
1-006.04C; for example, transmission has a signal less than 384 kbps.

1-006.06B Negligible Transmission Time: Transmission costs are not covered when
transmission time is negligible. Transmission time is negligible in instances such as, but not
limited to, the store and forward transmission of data sent for professional review and
interpretation. Transmission time less than 5 minutes for a telehealth service is deemed
negligible for Medicaid payment purposes under this section.

1-006.06D Medicare/Insurance Covered Telehealth Service: Providers shall not bill Medicaid or
the client for transmission costs incurred as part of a Medicare covered telehealth service and
excluded from Medicare coverage. If the practitioner bills insurance or other third party liability
entity for the telehealth service, and payment for the telehealth service includes payment for
transmission costs, the provider shall not bill Medicaid separately for transmission costs.

1-006.06E Non-Covered Telehealth Services: Transmission costs are not covered when the
telehealth service provided by the health care practitioner is not covered under these
regulations.

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1-006.07 Rural Health Clinic and Federally Qualified Health Center Encounter Rates: Telehealth services are not covered under the encounter rate for rural health clinic (RHC) core services and federally qualified health center (FQHC) core services where reimbursement is based on a "face to face" encounter between a provider and a patient. See 42 CFR 405.2463 (a) (1) and (2); 447.371 (d); and 440.20 (b) (1) and (2). See 471 NAC 29-003.01.

Telehealth services provided by a RHC or FQHC may be covered at a fee-for-service rate per the telehealth regulations using non-RHC and non-FQHC core service provider numbers.

1-006.08 Tribal 638 Clinic Services: Telehealth services are not covered under the reimbursement for core services billed under an encounter rate. Telehealth services provided by Tribal 638 Clinics may be covered under these telehealth regulations for other services billed at the fee-for-service rates.

1-006.09 Nursing Facility Periodic Physician Visits: Telehealth coverage is not available for physician visits to clients in nursing facilities (NF) required on the periodic schedule of at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. This periodic schedule of visits is required for nursing facility certification under regulations that require that a client "be seen" by the physician. See 471 NAC 12-007.09 and 42 CFR 483.40 (c) (1).

1-006.10 Other Requirements and Limitations for Telehealth Services

1-006.10A Informed Consent: Before an initial telehealth service, the practitioner who delivers the service to a client shall ensure that the following written information is provided to the client in a form and manner which the client can understand, using reasonable accommodations when necessary, that:

1. S/he retains the option to refuse the telehealth service at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the client would otherwise be entitled;
2. Alternative options are available, including in-person services, and these options are specifically listed on the client’s informed consent statement;

3. All existing confidentiality protections apply to the telehealth consultation;

4. S/he has access to all medical information resulting from the telehealth consultation as provided by law for patient access to his/her medical records;

5. The dissemination of any client identifiable images or information from the telehealth consultation to anyone, including researchers, will not occur without the written consent of the client;

6. S/he has a right to be informed of the parties who will be present at each end of the telehealth consultation and s/he has the right to exclude anyone from either site; and

7. S/he has a right to see an appropriately trained staff or employee in-person immediately after the telehealth consultation if an urgent need arises, or to be informed ahead of time that this is not available as provided in 471 NAC 1-006.10B Support at Client Site.

The health care practitioner shall ensure that the client’s informed consent has been obtained before providing the initial service. The client’s signature indicates that s/he understands the information, has discussed this information with the health care practitioner or his/her designee, and understands the informed consent may apply to follow-up telehealth services with the same practitioner. The health care practitioner providing the telehealth service or staff at the client site shall retain the signed statement, and the statement must become a part of the client’s medical record. A copy of the signed informed consent must also be given to the client.
If the client is a minor or is incapacitated or is mentally incompetent such that s/he is unable to sign the statement, the client’s legally authorized representative shall sign the informed consent statement to give consent. The health care practitioner providing the telehealth service or staff at the client site shall retain the signed statement, and the statement must become a part of the client’s medical record. A copy of the signed informed consent must also be given to the client’s legally authorized representative.

The requirement to obtain written informed consent before providing a service does not apply in emergency situations where the client is unable to sign the written statement as required above and the client’s legally authorized representative is unavailable. However, within 72 hours after the telehealth service is provided, the health care practitioner shall obtain the signature of the client or his/her legally authorized representative on the informed consent form indicating s/he has been informed that a telehealth service was delivered and all the written statements in the informed consent statement apply. The health care practitioner providing the telehealth service or staff at the client site shall retain the signed statement, and the statement shall become a part of the client’s medical record. A copy of the signed informed consent must also be given to the client or to the client’s legally authorized representative.

A sample informed consent statement is available from the Department upon request. (See suggested form in 471-00-10 of the appendix)

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1-006.10B Support at Client Site: An appropriately trained staff or employee familiar with the client’s treatment plan or familiar to the client must be immediately available in-person to the client receiving a telehealth service to attend to any urgencies or emergencies that may occur during the service. "Immediately available" means the staff or employee must be either in the room or in the area outside the telehealth room in easy access for the client. This requirement may be waived on an individual client basis for repetitive services when documentation shows that a safe routine has been established for the client, such as for a home health service, and that the client has consented to this exception. The health care practitioner providing the telehealth service shall document this fact in the medical record, with the rationale as to why an
appropriately trained staff or employee need not be immediately available.

1-006.10C Quality Assurance Requirements: Each telehealth site shall have established written quality of care protocols and patient confidentiality guidelines to ensure telehealth services meet the requirements of state and federal laws and established professional patient care standards. Prior to initial billing for telehealth services, each telehealth site shall submit two copies of a letter to the Department, addressed to the Medicaid Medical Director:

1. Certifying written quality of care protocols are operational at the sites where telehealth services are provided;

2.

3.

4.
5.

The provider shall make the protocols and guidelines available for inspection at the telehealth site and to the Department upon request. The provider shall send any changes to the written submitted information to the Department in writing prior to billing under the changes. (Also see 471 NAC 1-006.10F, Medical Records; and 1-006.10G, Confidentiality and Integrity of Data.)

1-006.10D Out-of-State Services: Under 42 CFR 431.52 and 471 NAC 1-002.02G, Nebraska Medicaid covers telehealth services furnished in another state to the same extent it would pay for telehealth services furnished in Nebraska if the services are furnished to a client who is a resident of Nebraska but who is physically located in another state at the time the service is delivered, and any of the following conditions are met:

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1. Medical services are needed because of a medical emergency;

2. Medical services are needed and the client’s health would be endangered if s/he were required to travel to his/her state of residence;
3. The Department determines, on the basis of medical advice, the needed medical services, or necessary supplementary resources, are more readily available in the other state; or

4. It is general practice for clients in a particular locality to use medical resources in another state.

The practitioner providing the telehealth service to a Nebraska Medicaid client while the client is physically located in another state must meet the requirements for provider participation in 471 NAC 1-006.03 except for item 3. Instead of item 3, the practitioner must be appropriately licensed, certified, or registered by the state agency in that state for the service billed to Nebraska Medicaid.

All prior authorization requirements for out-of-state services must be met.

1-006.10E Requirements for Services to Medicaid Eligible Persons with Other Health Care Coverage:

1-006.10E1 Medicare/Medicaid Eligible Clients: All Medicare-covered services must first be billed to Medicare. Medicaid does not cover services denied by Medicare for lack of medical necessity. Medicaid pays only coinsurance and deductibles for Medicare-covered services. No additional payments will be made for transmission costs for Medicare-covered services.

1-006.10E2 Clients with Other Health Care Coverage: Because Medicaid is the payer of last resort, services must first be billed to other liable third party payers. When a service is covered by a third party payer and includes the transmission costs, Medicaid will not make an additional payment for the transmission costs.

1-006.10F Medical Records: The practitioner shall keep a complete medical record on all telehealth services provided to clients, following all applicable statutes and regulations for medical record keeping and confidentiality. The use of telehealth technology must be appropriately documented in the medical record, including the treatment plan, progress notes, and treatment plan reviews.
In addition, the medical record must include the following:

1. A full notation describing the health care service delivered via telecommunication technology and indicating which site initiated the call;

2. A list of the telehealth technologies used for the service (e.g., real-time two-way interactive audio-visual transmission via a T1 line; digitalized radiology transmission via store and forward technology; electronic stethoscope; etc.);

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3. Documentation showing the time the service began and ended;

4. When applicable, a notation by the practitioner that a copy of the required signed telehealth informed consent statement is in the client’s record at the site where the client is physically located (see 471 NAC 1-006.10A Informed Consent);

5. Documentation in the medical record supporting the need for the level of care delivered via telehealth, and

6. When applicable, reasons for an exception to the 30-mile distance requirement (see 471 NAC 1-006.05E).

1-006.10G Confidentiality and Integrity of the Data: All confidentiality laws and other
requirements that apply to written medical records shall apply to electronic medical records, including the actual transmission of the service and any recordings made during the time of the transmission.

All transmissions must be performed on a dedicated secure line or must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.

Providers of telehealth services shall implement confidentiality protocols that include, but are not limited to:

1. specifying the individuals who have access to electronic records;

2. usage of unique passwords or identifiers for each employee or other person with access to the client records;

3. ensuring a system to prevent unauthorized access, particularly via the internet or intranet; and

4. ensuring a system to routinely track and permanently record access to such electronic medical information.

1-006.11 Payment Methodology: The Nebraska Medical Assistance Program (NMAP) pays for covered telehealth services and transmission costs as follows:

1-006.11A Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.
1-006.11B Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of:

1. The provider’s submitted charge; or

2. The maximum allowable amount. (See the appropriate Nebraska Medicaid Practitioner Fee Schedule in effect for the date of service.)

The Medicaid maximum allowable is determined by using the highest USF subsidized monthly rate in Nebraska for transmission up to a T1 line, assuming an 8 hour per day/5 days per week usage to determine a per minute unit reimbursement. The Medicaid maximum allowable rate for transmission costs may be reviewed periodically by the Department.

1-006.12 Billing Requirements: Providers of telehealth services shall bill Medicaid for services provided via telecommunication technology according to the Medicaid requirements and claim submission instructions for the service type.

Only the provider incurring the cost of a transmission shall bill for the telehealth transmission cost. Providers shall bill transmission costs at the rate charged the general public. Providers shall bill the transmission costs for the actual length of time of the transmission of the telehealth service.

Reimbursement is not available for stand-by time when the sites are in contact but either the patient or the provider is not available for the service.
Attaching a sample copy of the provider’s informed consent form (see 471 NAC 1-006.10A). Documenting that the telehealth technologies meet the standards in 471 NAC 1-006.04C, and naming an authorized contact person with his/her phone number; listing the facility provider number, the names of all health care practitioners providing telehealth services and their Medicaid provider identification numbers, and the services provided at that site; certifying written patient confidentiality protocols are operational at the sites where telehealth services are provided;

nature between two or more persons exchanged via facsimile (FAX) over the Public Switched Telephone Network (PSTN) or other public or private data communications networks including the Internet.

FDA means the federal Food and Drug Administration.

H.320 means the industry-wide compressed audiovideo communication standard from the International Telecommunications Union (ITU) for real time, two-way interactive audiovideo transmission with a minimum signal of 384 kbps (kilobits per second) over a dedicated line; this may include a switched connection.

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MANUAL LETTER # 64-2000 AND SUPPORT MANUAL 471 NAC 1-006.02

Health Care Practitioner means a health care professional who is licensed, certified, or registered with Nebraska Department of Health and Human Services Regulation and Licensure or with the comparable agency in the state in which s/he practices his/her profession.
Health Care Practitioner Facility means the residence, office, or clinic or a practitioner or group of practitioners who are enrolled with Medicaid and credentialed under the Uniform Licensing Law or any distinct part of such residence, office, or clinic.

Legally Authorized Representative means the client's parent if the client is a minor child, a legal guardian, or a person with power of attorney for the client.

T1 Line means a digital transmission service of 1.544 Mbps.

Telehealth means the use of telecommunications technology by a health care practitioner to deliver health care services within his or her scope of practice to a patient located at a site other than the site where the practitioner is located.

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Telephone means an instrument for reproducing sounds at a distance; specifically, one in which sound is converted into analog or digital signals for transmission by wire or other modality.
Transmission Cost means the cost of the line charge incurred during the time of the transmission of a telehealth service.

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MANUAL LETTER # 64-2000 AND SUPPORT MANUAL 471 NAC 1-006.03

1-006.03 Standards for Provider Participation:

Health care practitioners must:

1. Act within their scope of practice;

2. Be enrolled with NMAP; and

3. Be appropriately licensed, certified, or registered by the Nebraska HHS Regulation and Licensure agency for the service for which they bill Medicaid. (An exception to this requirement may be allowed when the telehealth service is delivered out-of-state and covered under 471 NAC 1-006.10D Out of State Services.)

Entities enrolled as Medicaid providers other than practitioners (such as hospitals) which bill for practitioner services may bill for telehealth services when the practitioner providing the service meets the above requirements.
In providing telehealth services, health care practitioners and health care facilities shall follow all applicable state and federal laws and regulations governing their practice, including, but not limited to, the requirements for maintaining confidentiality and obtaining informed consent.

Prior to billing Medicaid for any telehealth services, each telehealth site must submit a letter (2 copies) to the Department as required under 471 NAC 1-006.10C regarding quality assurance issues.

1-006.04 Coverage for Telehealth Services and Transmission Costs: Effective July 1, 2000, Medicaid services that are otherwise covered in the NMAP and are provided via telecommunication technologies may be reimbursed under the conditions and limitations set forth in these regulations. Payment for telehealth services must be consistent with the federal requirements of efficiency, economy, and quality. In-person contact between a health care provider and a client is not required under the NMAP telehealth regulations except where otherwise required by federal statute or regulation.

Services otherwise covered by NMAP and delivered via telecommunications technology may be reimbursed when the following conditions are met:

1-006.04A Health Care Practitioner Requirement: Telehealth services are covered only when provided by a health care practitioner meeting the requirements in 471 NAC 1-006.03 Standards for Provider Participation.

1-006.04B NMAP 471 and 482 NAC Requirements: Services provided via telehealth are subject to all current NMAP regulations in 471 and 482 NAC including, but not limited to, the requirement:

1) that services are medically necessary and appropriate to the client’s condition;
2) that active treatment for mental health/substance abuse services is met; and

3) that the service provided is a generally accepted standard of care.

REV. OCTOBER 15, 2003 NEBRASKA HHS FINANCE NMAP SERVICES

MANUAL LETTER # 59-2003 AND SUPPORT MANUAL 471 NAC 1-006.04C

1-006.04C Telecommunications Technology: Coverage is only available for telehealth services and for telehealth transmission costs when, at a minimum, the H.320 or H.323 audiovisual standards for real time, two-way interactive audiovisual transmission are met or when any analog or alternate transmission technology system equals or exceeds the H.320 or H.323 standard for clarity and quality. The Department may request an independent expert opinion as to whether a provider's system meets the technology standards for this requirement.

In addition, the telecommunication technology and equipment used at the client site and at the practitioner site must be sufficient to allow the health care practitioner to appropriately evaluate, diagnose, or treat the client or to appropriately accomplish the service billed to Medicaid. At a minimum, the equipment must be of a level of quality to accomplish the level of service and to adequately complete all necessary components as defined in the national standard code sets billed to NMAP.

If a peripheral diagnostic scope or device is required to assess the client, it must provide adequate resolution or audio quality for decision making via telehealth.

Coverage is available for teleradiology services when these services meet the American College of Radiology standards for teleradiology (see ACR Standard for Teleradiology: Revised 1998 (Res.35) Effective 1/1/99 as amended – attached and incorporated by reference).
1-006.04D Prior Authorization: All prior authorization requirements outlined in 471 and 482 NAC for specific services must be met to be covered as a telehealth service. Prior authorization requests must state the intent to provide the service as a telehealth service.

1-006.04E Transmission Costs: Transmission costs for line charges are allowable when directly related to a covered telehealth service and when the standards in 1-006.04C are met for real time, two-way interactive audio visual transmission.

Transmission costs may be covered as outlined in these regulations. However, transmission costs are not a separate billable service and are included in the payment for inpatient hospital services or in the per diem or per monthly payment for the other services below:

1. Inpatient Hospital Services, including general hospital as well as psychiatric and rehabilitation hospital services;

2. Nursing Facility Services;

3. Intermediate Care Facility-Mentally Retarded (ICF-MR) Services;

4. Assisted Living Facility Services;

5. Residential Treatment Center Services;

6. Treatment Group Home Services;

7. Day Treatment Facility Services;
8. Treatment Foster Care Services;

9. Mental Health/Substance Abuse Crisis Facility Services; and


When a client receives a telehealth service as part of the services listed above, the transmission service must be reported on each individual claim and on the facility’s cost report.

1-006.04F Managed Care: Coverage of services delivered via telecommunications technology under contracted Medicaid managed care plans is required to the extent that coverage and reimbursement is available under the Medicaid fee-for-service program. In the event that coverage of services delivered through telehealth proves not to be cost neutral, the appropriate capitation rates may be adjusted.

No fee-for-service coverage outside the managed care plan is available for telehealth services for clients enrolled in managed care.

All managed care referral procedures and authorization requirements shall be followed (see Title 482 NAC).

1-006.05 Non-Covered Telehealth Services: Services provided via telehealth technologies are not covered when any one of the following conditions is met:
1-006.05A Non-Covered Medicaid Services: Services not otherwise covered by Nebraska Medicaid are not covered when delivered via telehealth.

1-006.05B Services Excluded from Coverage as a Telehealth Service: Services covered under other Medicaid regulations but specifically excluded from telehealth coverage are:

1. Medical Equipment and Supplies provided by DME (Durable Medical Equipment) suppliers and pharmacies;

2. Orthotics and Prosthetics provided by DME suppliers and pharmacies;

3. Personal care aide (PCA) services;

4. Home Health Aide Services;

5. Pharmacy services for prescribed drugs;

6. Home and Community Based Waiver services provided by persons who do not meet the standards for a practitioner of telehealth services in 471 NAC 1-006.03;

7. Mental Health, Substance Abuse, and Psychiatric Rehabilitation services provided by persons who do not meet the standards for a practitioner of telehealth services in 471 NAC 1-006.03 (e.g., Community Treatment Aids; Certified Alcohol and Drug Abuse Counselors; Ph. D. candidates who are not licensed or certified; and other enrolled professionals who are not licensed, certified, or registered by HHS – Regulation and Licensure);
8. Medical Transportation services, including ambulance services;

9. Federal Qualified Health Center core services billed as an "encounter" service;

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10. Rural Health Clinic core services billed as an "encounter" service;

11. Physician visits to clients in nursing facilities required on the specified periodic schedule for nursing facility certification;

12. Tribal 638 Clinic core services billed as an "encounter" service;

13. Services requiring "hands on" professional services such as eye glass fittings and hearing aid fittings;

14. Services provided in public schools by staff who are not licensed, certified, or registered with HHS – Regulation and Licensure;

15. Ambulatory Room and Board services; and

16. Other services that do not meet the requirements of these telehealth regulations.
1-006.05C Inappropriate Telecommunications Technologies: Coverage is not available when the minimum standards for telecommunication technologies in 471 NAC 1-006.04C are not met or when the technologies used are not appropriate for the service delivered and billed to Medicaid.

1-006.D Free to the General Public: Medicaid does not reimburse services that are provided free to the general public. See 471 NAC 3-001.02D and 2-001.03(1 through 5).

1-006.05E Distance Requirement: Services provided via telecommunications technologies are not covered if the client has access to a comparable service within 30 miles of his/her place of residence. This requirement does not apply:

1. In emergency or urgent medical situations;

2. When accessing the appropriate service at a distance less than 30 miles poses a significant hardship on the client due to a medical condition or disability; or

3. To clients residing in nursing facilities who require transportation to the appropriate service via ambulance.

When billing a telehealth service or transmission cost within a 30 mile radius of the client’s place of residence, one of the above three reasons must be documented in the medical record and available to the Department upon request.

1-006.05F E-Mail, Telephone, and Facsimile Transmissions: Telehealth services provided via e-mail, telephone, or facsimile transmissions are not covered.

1-006.05G Devices Subject to FDA Approval: Medicaid does not cover services that utilize a
device or telecommunication technology subject to FDA approval but not FDA approved for the
telehealth service. However, FDA approval does not guarantee coverage of a service.

1-006.05H Prescriptions over the Internet: Neither the prescribing health care practitioner
service nor the pharmacy service is covered when the health care practitioner prescribing the
medication has only reviewed an e-mail message or e-mail questionnaire about the client.

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1-006.05I Investigational/Experimental Services: A telehealth service is not covered when the
service delivered via telecommunication technology is deemed to be investigational or
experimental under 471 NAC 1-002.02C. Even though a service is covered when provided
in-person to a client, the service may be deemed investigational/experimental for Medicaid
payment purposes when provided via telecommunications technology. (Also, see 471 NAC
1-006.05G regarding devices requiring FDA approval.)

An example of a service excluded from telehealth coverage because the services are deemed
investigational/experimental or do not meet current accepted standards of medical care is as
follows: surgery performed by a mechanical device operated by a practitioner who is at a site
different from where the patient is located.

1-006.05J Services Requiring Direct Physical Contact with a Practitioner: Services that require
direct physical contact with a client by a health care practitioner and that cannot be delegated to
another health care practitioner at the site where the client is located are not covered.

1-006.06 Non-Covered Transmission Costs

1-006.06A Low Transmission Capacity: Transmission costs are not covered when the real time,
two-way interactive audio-visual transmission is below the standards stated in 471 NAC 1-006.04C; for example, transmission has a signal less than 384 kbps.

1-006.06B Negligible Transmission Time: Transmission costs are not covered when transmission time is negligible. Transmission time is negligible in instances such as, but not limited to, the store and forward transmission of data sent for professional review and interpretation. Transmission time less than 5 minutes for a telehealth service is deemed negligible for Medicaid payment purposes under this section.

1-006.06D Medicare/Insurance Covered Telehealth Service: Providers shall not bill Medicaid or the client for transmission costs incurred as part of a Medicare covered telehealth service and excluded from Medicare coverage. If the practitioner bills insurance or other third party liability entity for the telehealth service, and payment for the telehealth service includes payment for transmission costs, the provider shall not bill Medicaid separately for transmission costs.

1-006.06E Non-Covered Telehealth Services: Transmission costs are not covered when the telehealth service provided by the health care practitioner is not covered under these regulations.

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1-006.07 Rural Health Clinic and Federally Qualified Health Center Encounter Rates: Telehealth services are not covered under the encounter rate for rural health clinic (RHC) core services and federally qualified health center (FQHC) core services where reimbursement is based on a "face to face" encounter between a provider and a patient. See 42 CFR 405.2463 (a) (1) and (2); 447.371 (d); and 440.20 (b) (1) and (2). See 471 NAC 29-003.01.

Telehealth services provided by a RHC or FQHC may be covered at a fee-for-service rate per the telehealth regulations using non-RHC and non-FQHC core service provider numbers.
1-006.08 Tribal 638 Clinic Services: Telehealth services are not covered under the reimbursement for core services billed under an encounter rate. Telehealth services provided by Tribal 638 Clinics may be covered under these telehealth regulations for other services billed at the fee-for-service rates.

1-006.09 Nursing Facility Periodic Physician Visits: Telehealth coverage is not available for physician visits to clients in nursing facilities (NF) required on the periodic schedule of at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. This periodic schedule of visits is required for nursing facility certification under regulations that require that a client "be seen" by the physician. See 471 NAC 12-007.09 and 42 CFR 483.40 (c) (1).

1-006.10 Other Requirements and Limitations for Telehealth Services

1-006.10A Informed Consent: Before an initial telehealth service, the practitioner who delivers the service to a client shall ensure that the following written information is provided to the client in a form and manner which the client can understand, using reasonable accommodations when necessary, that:

1. S/he retains the option to refuse the telehealth service at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the client would otherwise be entitled;

2. Alternative options are available, including in-person services, and these options are specifically listed on the client’s informed consent statement;

3. All existing confidentiality protections apply to the telehealth consultation;

4. S/he has access to all medical information resulting from the telehealth consultation as provided by law for patient access to his/her medical records;
5. The dissemination of any client identifiable images or information from the telehealth consultation to anyone, including researchers, will not occur without the written consent of the client;

6. S/he has a right to be informed of the parties who will be present at each end of the telehealth consultation and s/he has the right to exclude anyone from either site; and

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7. S/he has a right to see an appropriately trained staff or employee in-person immediately after the telehealth consultation if an urgent need arises, or to be informed ahead of time that this is not available as provided in 471 NAC 1-006.10B Support at Client Site.

The health care practitioner shall ensure that the client’s informed consent has been obtained before providing the initial service. The client’s signature indicates that s/he understands the information, has discussed this information with the health care practitioner or his/her designee, and understands the informed consent may apply to follow-up telehealth services with the same practitioner. The health care practitioner providing the telehealth service or staff at the client site shall retain the signed statement, and the statement must become a part of the client’s medical record. A copy of the signed informed consent must also be given to the client.

If the client is a minor or is incapacitated or is mentally incompetent such that s/he is unable to sign the statement, the client’s legally authorized representative shall sign the informed consent statement to give consent. The health care practitioner providing the telehealth service or staff at the client site shall retain the signed statement, and the statement must become a part of the client’s medical record. A copy of the signed informed consent must also be given to the client’s legally authorized representative.
The requirement to obtain written informed consent before providing a service does not apply in emergency situations where the client is unable to sign the written statement as required above and the client’s legally authorized representative is unavailable. However, within 72 hours after the telehealth service is provided, the health care practitioner shall obtain the signature of the client or his/her legally authorized representative on the informed consent form indicating s/he has been informed that a telehealth service was delivered and all the written statements in the informed consent statement apply. The health care practitioner providing the telehealth service or staff at the client site shall retain the signed statement, and the statement shall become a part of the client’s medical record. A copy of the signed informed consent must also be given to the client or to the client’s legally authorized representative.

A sample informed consent statement is available from the Department upon request. (See suggested form in 471-00-10 of the appendix)

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1-006.10B Support at Client Site: An appropriately trained staff or employee familiar with the client’s treatment plan or familiar to the client must be immediately available in-person to the client receiving a telehealth service to attend to any urgencies or emergencies that may occur during the service. "Immediately available" means the staff or employee must be either in the room or in the area outside the telehealth room in easy access for the client. This requirement may be waived on an individual client basis for repetitive services when documentation shows that a safe routine has been established for the client, such as for a home health service, and that the client has consented to this exception. The health care practitioner providing the telehealth service shall document this fact in the medical record, with the rationale as to why an appropriately trained staff or employee need not be immediately available.

1-006.10C Quality Assurance Requirements: Each telehealth site shall have established written quality of care protocols and patient confidentiality guidelines to ensure telehealth services meet the requirements of state and federal laws and established professional patient care standards. Prior to initial billing for telehealth services, each telehealth site shall submit two copies of a letter to the Department, addressed to the Medicaid Medical Director:
1. Certifying written quality of care protocols are operational at the sites where telehealth services are provided;

2. 

3. 

4. 

5. 

6.
Attaching a sample copy of the provider’s informed consent form (see 471 NAC 1-006.10A).

The provider shall make the protocols and guidelines available for inspection at the telehealth site and to the Department upon request. The provider shall send any changes to the written submitted information to the Department in writing prior to billing under the changes. (Also see 471 NAC 1-006.10F, Medical Records; and 1-006.10G, Confidentiality and Integrity of Data.)
resident of Nebraska but who is physically located in another state at the time the service is delivered, and any of the following conditions are met:

1. Medical services are needed because of a medical emergency;

2. Medical services are needed and the client's health would be endangered if s/he were required to travel to his/her state of residence;

3. The Department determines, on the basis of medical advice, the needed medical services, or necessary supplementary resources, are more readily available in the other state; or

4. It is general practice for clients in a particular locality to use medical resources in another state.

The practitioner providing the telehealth service to a Nebraska Medicaid client while the client is physically located in another state must meet the requirements for provider participation in 471 NAC 1-006.03 except for item 3. Instead of item 3, the practitioner must be appropriately licensed, certified, or registered by the state agency in that state for the service billed to Nebraska Medicaid.

All prior authorization requirements for out-of-state services must be met.

1-006.10E Requirements for Services to Medicaid Eligible Persons with Other Health Care Coverage:
1-006.10E1 Medicare/Medicaid Eligible Clients: All Medicare-covered services must first be billed to Medicare. Medicaid does not cover services denied by Medicare for lack of medical necessity. Medicaid pays only coinsurance and deductibles for Medicare-covered services. No additional payments will be made for transmission costs for Medicare-covered services.

1-006.10E2 Clients with Other Health Care Coverage: Because Medicaid is the payer of last resort, services must first be billed to other liable third party payers. When a service is covered by a third party payer and includes the transmission costs, Medicaid will not make an additional payment for the transmission costs.

1-006.10F Medical Records: The practitioner shall keep a complete medical record on all telehealth services provided to clients, following all applicable statutes and regulations for medical record keeping and confidentiality. The use of telehealth technology must be appropriately documented in the medical record, including the treatment plan, progress notes, and treatment plan reviews.

In addition, the medical record must include the following:

1. A full notation describing the health care service delivered via telecommunication technology and indicating which site initiated the call;

2. A list of the telehealth technologies used for the service (e.g., real-time two-way interactive audio-visual transmission via a T1 line; digitalized radiology transmission via store and forward technology; electronic stethoscope; etc.).
3. Documentation showing the time the service began and ended;

4. When applicable, a notation by the practitioner that a copy of the required signed telehealth informed consent statement is in the client’s record at the site where the client is physically located (see 471 NAC 1-006.10A Informed Consent);

5. Documentation in the medical record supporting the need for the level of care delivered via telehealth, and

6. When applicable, reasons for an exception to the 30-mile distance requirement (see 471 NAC 1-006.05E).

1-006.10G Confidentiality and Integrity of the Data: All confidentiality laws and other requirements that apply to written medical records shall apply to electronic medical records, including the actual transmission of the service and any recordings made during the time of the transmission.

All transmissions must be performed on a dedicated secure line or must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.

Providers of telehealth services shall implement confidentiality protocols that include, but are not limited to:

1. specifying the individuals who have access to electronic records;

2. usage of unique passwords or identifiers for each employee or other person with access to the client records;
3. ensuring a system to prevent unauthorized access, particularly via the internet or intranet; and

4. ensuring a system to routinely track and permanently record access to such electronic medical information.

1-006.11 Payment Methodology: The Nebraska Medical Assistance Program (NMAP) pays for covered telehealth services and transmission costs as follows:

1-006.11A Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

1-006.11B Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of:

1. The provider’s submitted charge; or

2. The maximum allowable amount. (See the appropriate Nebraska Medicaid Practitioner Fee Schedule in effect for the date of service.)

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The Medicaid maximum allowable is determined by using the highest USF subsidized monthly rate in Nebraska for transmission up to a T1 line, assuming an 8 hour per day/5 days per week...
usage to determine a per minute unit reimbursement. The Medicaid maximum allowable rate for transmission costs may be reviewed periodically by the Department.

1-006.12 Billing Requirements: Providers of telehealth services shall bill Medicaid for services provided via telecommunication technology according to the Medicaid requirements and claim submission instructions for the service type.

Only the provider incurring the cost of a transmission shall bill for the telehealth transmission cost. Providers shall bill transmission costs at the rate charged the general public. Providers shall bill the transmission costs for the actual length of time of the transmission of the telehealth service.

Reimbursement is not available for stand-by time when the sites are in contact but either the patient or the provider is not available for the service.

Documenting that the telehealth technologies meets the standards in 471 NAC 1-006.04C, and Naming an authorized contact person with his/her phone number; Listing the facility provider number, the names of all health care practitioners providing telehealth services and their Medicaid provider identification numbers, and the services provided at that site; Certifying written patient confidentiality protocols are operational at the sites where telehealth services are provided;