What You Need to Know About TELEMEDICINE

By Calvin B. Marshall, Jr., JD

You have undoubtedly observed and experienced the rapid, and relatively recent, rise of the healthcare industry phenomenon commonly referred to as "telemedicine" or, more broadly, "telehealth," concurrent with rapid advances in technology.[1] And you have likely seen that telemedicine-related issues are high on legislative agendas—both at the federal and state levels.[2]

Due in part to the rapid rise of this industry and the pace of change in both legal requirements and payor policies, billing for telemedicine services presents many compliance challenges and issues of which to be aware. Although the universe of telemedicine-related compliance issues is large, this article provides a high-level overview of key requirements and payor issues to consider in billing for telemedicine services or assisting clients in evaluating telemedicine initiatives.

Healthcare Practitioner Licensure

Practitioner licensure is an obvious, "top-of-the-list" issue when billing for healthcare services in the context of telemedicine. The physical location of the patient, as opposed to the location of the practitioner, is a key issue. Healthcare practitioners must be licensed and/or registered in some fashion if they are deemed to be practicing medicine in a particular state through telemedicine, although state requirements frequently contain exceptions, such as for "provider-to-provider" consultations.[3] Careful consideration of state requirements is necessary to (1) identify what type of telemedicine activities trigger licensure requirements (e.g., for physicians, identifying what activities constitute the practice of medicine in a particular state), and (2) determine what type of licensure or registration is necessary. As a general matter, treating patients via telemedicine will in most cases require full licensure in the state where the patients are located.[4]

As to the type of activities that trigger licensure requirements, state licensure law varies and may encompass telemedicine activities with more or less specificity. Georgia law, for example indicates that an out-of-state person practices medicine in Georgia by providing a patient care service affecting the diagnosis or treatment of an in-state patient via electronic or other means of telecommunication.[5] Other states, such as West Virginia, specifically define telemedicine practice using the term "telemedicine," and require licensure for such practice.[6] In reviewing these requirements,

it is also important to consider the exceptions often set forth in state licensure laws. Georgia's statute, for example, contains a variety of exceptions for activities, such as consultation services provided at the request of a physician licensed in Georgia (i.e., a "provider-to-provider consultation" exception) or provided in an emergency.[7]

However, as for the type of licensure or registration, most states require a full physician license—although some states maintain reciprocity provisions with bordering states, and a substantial minority of states have adopted the Federation of State Medical Boards (FSMB) Interstate Medical Licensure Compact to streamline licensure.[8] Alternatively, some states allow physicians fully licensed in other states to obtain special "telemedicine" licenses or provide consultations to patients if the physicians register in the patients' state and meet certain other requirements.[9] Thus, review of the applicable requirements in each state is essential when considering providing services via telemedicine.[10]

uation prior to the performance of telemedicine services, and (3) whether an in-person follow up visit is required after provision of telemedicine services. There are a number of variations on these types of requirements. For example, under Tennessee law, a physician-patient relationship may be established via telemedicine, among other means, whether or not there has been an encounter in person between the physician and patient and without a referral from another practitioner who saw the patient in person.[11] States are increasingly taking this type of approach. In contrast, under the law of other states, such as Arkansas and Georgia, an in-person physical examination may be required prior to provision of telemedicine services in certain instances. Although there are some exceptions to the in-person examination requirements under the laws of these states, including conducting an examination via telemedicine that is equivalent to an in-person examination, such exceptions may not always apply or be appropriate for certain

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Other State Requirements for Telemedicine Encounters

Beyond licensure, state laws impose a variety of requirements impacting telemedicine practice. Although comprehensive review of all such requirements is beyond the scope of this article, a number of key issues are outlined below:

ESTABLISHING A PROVIDER-PATIENT RELATIONSHIP AND RELATED REQUIREMENTS

Before providing medical consultations or other services via telemedicine, healthcare practitioners should consider issues such as (1) whether (and how) a provider-patient relationship may be established via telemedicine, (2) whether a provider (or the referring provider) must have an established relationship with a patient or conduct a physical exam/evaluation prior to the performance of telemedicine services, and (3) whether an in-person follow up visit is required after provision of telemedicine services. There are a number of variations on these types of requirements. For example, under Tennessee law, a physician-patient relationship may be established via telemedicine, among other means, whether or not there has been an encounter in person between the physician and patient and without a referral from another practitioner who saw the patient in person.[11] States are increasingly taking this type of approach. In contrast, under the law of other states, such as Arkansas and Georgia, an in-person physical examination may be required prior to provision of telemedicine services in certain instances. Although there are some exceptions to the in-person examination requirements under the laws of these states, including conducting an examination via telemedicine that is equivalent to an in-person examination, such exceptions may not always apply or be appropriate for certain specialties or under applicable standards of care.[12] Furthermore, a few states require in-person visits in connection with telemedicine visits, even if such visits are not required in advance. For example, Georgia law requires that healthcare practitioners treating a patient through electronic means "make diligent efforts" to have the patient examined in person at least annually.[13] Texas has had a similar annual requirement, in addition to having a variety of other strict requirements concerning in-person evaluations, including an advance in-person evaluation provision and a "new symptom" in-person evaluation provision, although Texas requirements are likely about to change.[14]

TELEPRESENTERS/FACILITATORS

Healthcare practitioners should be aware that telemedicine

requirements vary in some states based on whether a "telepresenter" (i.e., a licensed healthcare practitioner) is available at the patient site to present the patient to the distant site practitioner for the telemedicine encounter. For example, under Texas law, the range of care that healthcare practitioners may provide via telemedicine is greater when a telepresenter is available.[15] Other states have similar concepts that impact applicable requirements. Tennessee has the somewhat similar concept of "facilitator," which is an individual such as a parent/legal guardian or individual affiliated with a local system of care who is physically present with the patient during the telemedicine encounter to verify the identify and location of the patient and to assist in the exchange of data. Without a facilitator, patients under the age of 18 cannot be treated via telemedicine unless otherwise authorized by law.[16]

INFORMED CONSENT REQUIREMENTS

Many states have informed consent requirements that are specific to telemedicine. All healthcare practitioners are well advised to obtain and document informed consent prior to the provision of telemedicine services. However, individual state requirements should be considered. For example, Arizona requires that, with certain exceptions, healthcare practitioners obtain written or verbal informed consent from patients (and verbal informed consent must be documented in the patient's medical record) before providing health care through telemedicine.[17]

TECHNOLOGY AND FORMAT CONSIDERATIONS

Healthcare practitioners should take into account any state-specific provisions concerning telemedicine technology and telemedicine encounter format. For example, Tennessee regulations, in defining telemedicine, state that telemedicine encounters typically involve the application of secure video conferencing, or store-and-forward technology, to support delivery of services by replicating a traditional encounter between the provider and patient.[18] Further, if no facilitator is present, the patient must utilize adequately sophisticated technology to enable the remote provider to verify the patient's identify and location with an appropriate level of confidence.[19] Potentially even more important is what is excluded from the definition of telemedicine, from a technological standpoint. Tennessee regulations, for example, state that telemedicine is not an audio only telephone conversation, e-mail/instant messaging conversation or facsimile.[20] Indiana law contains a somewhat similar exclusion list.[21] Taking a slightly different tack, some state laws restrict the format through which a physician-patient relationship may be established. Texas law, for example, states that an online questionnaire or questions and answers exchanged through e-mail, electronic text, chat or telephone evaluation of, or consultation with a patient are inadequate to establish a defined physician-patient relationship.[22] Healthcare practitioners should find out whether the laws of their particular states contain these types of provisions.[23]

e-Prescribing

Billing companies can help inform healthcare practitioner clients of the additional layer of regulations imposed at the federal and state level with respect to electronic prescribing. Federal law requires an in-person (physical presence) medical evaluation for electronic prescribing of controlled substances, although certain limited exceptions are available.[24] This restriction alone creates substantial hurdles to e-prescribing in the telemedicine context.[25] With that said, healthcare practitioners should also consider state law requirements with respect to e-prescribing. Although nearly all states have requirements or policies with respect to e-prescribing, some state laws impose requirements that differ from federal requirements. For example, Georgia defines as "unprofessional conduct" as the prescribing of any "controlled substances" or "dangerous drugs" under Georgia law based solely on an electronic consultation with the patient, with very limited exceptions.[26] Thus, state e-prescribing restrictions may go beyond controlled substances, as federally defined.[27] Due to these varying requirements, a careful review of state law is necessary.

State Corporate Practice of Medicine and Fee-Splitting Laws

If you are assisting clients in evaluating telemedicine-related ventures with non-medical third parties, you should ensure that your clients evaluate the implications of state corporate

practice of medicine and fee-splitting laws. Many, but not all, states have "corporate practice of medicine" laws designed to prevent non-professional business organizations from employing or contracting with physicians engaged in the "practice of medicine," and designed to ensure that licensed practitioners (physicians and certain other professionals) own and control the professional entities that are permitted to employ and contract with such practitioners.[28] Many states also have "fee-splitting" laws or doctrines (some arising under health professions codes and some arising under state Medicaid regulations) that prohibit physicians from dividing professional fees with non-physicians or non-professional entities.[29] Although careful structuring of business arrangements may allow parties to successfully avoid compliance issues with respect to these laws, such laws can present significant barriers to telemedicine ventures and should therefore be analyzed.

Payor Policies and Requirements

In addition to considering federal and state requirements with respect to licensure, establishing practitioner-patient relationships and other issues, you should evaluate payor and state law requirements with respect to telemedicine services. Below is a high-level overview of a few key issues.[30]

MEDICARE CONSIDERATIONS

Medicare requirements with respect to telemedicine vary by payment category, although you should expect the requirements within each of these categories to change and potentially grow less restrictive in the years ahead.

Under the first category, Medicare covers certain enumerated telemedicine services under the Physician Fee Schedule (PFS).[31] Telemedicine services may not be provided through "store-and-forward" technology in most locations, but must be provided through an interactive audio and video system that permits real-time communication between the practitioner at the distant site and the patient at the originating site (assignment of the GT modifier, which is used for these services, signifies that services have been rendered in this way).[32] Eligible distant site practitioners include physicians, nurse practitioners, physician assistants, and other healthcare practitioners who submit claims in their service area and receive the same rate they would receive for face-to-face services.[33]

Perhaps most importantly, telemedicine services under Medicare may only be rendered to a patient at a valid originating site, which must be in a rural area. Valid originating sites that are eligible to receive a PFS facility fee of $25[34] include physician/practitioner offices, hospitals, rural health clinics, and a limited number of other sites.[35]

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Except for entities participating in certain federal demonstration projects, such sites must be located in a county outside of a metropolitan statistical area (MSA) or a rural Health Professional Shortage Area (HPSA) located in a rural census tract of an MSA.[36] Unfortunately, this restriction means that Medicare payment for telemedicine services will not be available to many healthcare practitioners, and you should focus particular attention on this issue. The Medicare Payment Advisory Commission (MedPAC) indicated in a 2016 report that 55 percent of claims it studied did not include an originating site claim, and 44 percent of the claims without an originating site claim were associated with non-rural beneficiaries. Although it is possible some providers chose not to bill for the facility fee, this finding suggests that many telemedicine claims may have originated from invalid originating sites.[37]

Although not currently addressed in the 2017 Work Plan released by the Office of Inspector General (OIG) for the US Department of Health & Human Services, this may become a significant area of focus for the OIG and other authorities in the future.

Under the second Medicare category, which is the Medicare Advantage (MA) program, MA plans cover the same telemedicine services covered under Medicare Part B (PFS), although they can also cover supplemental telemedicine benefits beyond those covered by Medicare Part B with CMS's approval.[38] MA plans can typically cover the costs of supplemental benefits with rebate dollars—if the plan bid is below the regional benchmark—or supplemental patient premiums.[39] Thus, in determining particular MA plan requirements for telemedicine, you should keep general Medicare Part B requirements in mind while also familiarizing yourself with the requirements of particular MA plans, which may provide for additional or more flexible benefits.

Under the third, and last Medicare category, Medicare pays for telemedicine services through payment models being tested under CMS's Center for Medicare and Medicaid Innovation (CMMI).[40] Because CMS has the authority to waive certain Medicare requirements to test these models, you should also consider whether clients are participating in particular payment models—such as the Next Generation Accountable Care Organization model, where urban and home telemedicine services are permitted.[41]

STATE MEDICAID AND INSURANCE LAW CONSIDERATIONS

Telemedicine parameters and requirements with respect to Medicaid, under state law, and under private payor policies vary widely and should be carefully considered. CMS does not impose restrictions with respect to telemedicine under Medicaid, so states determine their own policies and requirements.[42] In 2016, MedPAC reported that of the 51 Medicaid programs in existence, 49 covered telehealth services to some extent.[43] States with more restrictive Medicaid telehealth policies included Connecticut, Florida, Idaho, Montana, and Rhode Island, while states with less restrictive requirements included Maine, New Mexico, and Virginia.[44]

Some of the foregoing state Medicaid program policies are impacted by individual state telemedicine "parity" laws, which set some parameters with respect to private payor policies and requirements. State "parity" laws generally require insurers within a particular state to cover telemedicine services in the same manner as services provided in-person, although specific requirements vary. Tennessee's telemedicine parity law, for example, applies to many types of private health insurers, with limited exceptions, and also applies to Medicaid managed care plans.[45] Although insurers have some discretion in determining "qualified sites" of the patient and distant site provider, telehealth policies must be consistent with policies concerning in-person encounters for the same service, and insurers must reimburse for care without consideration of geographic locations or classifications.[46] In its most recent survey, the American Telemedicine Association gave 24 states and the District of Columbia its highest grades for private insurance parity, while 26 states received "other" (lower) grades, with 20 states receiving "failing" grades.[47] States with the highest grades were those that mandate state-wide coverage with no provider, technology, or patient setting restrictions. State laws concerning telemedicine parity vary widely—you should take these varying requirements into account when assisting clients, and you should also take into account specific private payor policies within the parameters set by state law.[48]

Lastly, you may be called upon to assist clients with telemedicine ventures that fall into the realm of "concierge" medicine involving special fee agreements directly entered into with patients or their employers. Such ventures create a number of special considerations. A careful analysis of Medicare (including whether to "opt out" of Medicare) and state insurance laws, in particular, will be necessary in connection with these ventures. From a state law perspective, however, some states have begun to enact "direct primary care" and other laws to increase regulatory flexibility with respect to concierge medicine. Such laws have not been enacted in every state, however, and healthcare practitioners should gain an understanding of each applicable state's regulatory landscape with respect to concierge medicine when considering direct "concierge" arrangements with patients or employers.

As the foregoing discussion illustrates, the telemedicine space is complex, with a multitude of federal and state law and payor policy issues to consider. You should carefully evaluate these issues in assisting clients with establishing and billing for telemedicine services. Most importantly, members should remember that legal requirements in this area are rapidly changing at both state and federal levels. Policies and requirements that apply today may not apply tomorrow, so ongoing study will be required. Notwithstanding legal and other restrictions, which should continue to gradually diminish, the telehealth industry is currently experiencing rapid growth, which is expected to continue in the years ahead. Stay tuned for upcoming growth and changes in 2017 and beyond. ■

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Resources

[1] The 10,000-plus member American Telemedicine Association (ATA) defines telemedicine as, "the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Closely associated with telemedicine is the term 'telehealth,' which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services." "Telehealth and Telemedicine," Telemedicine Glossary, American Telemedicine Association, hub.americantelemedi.org/resources/telemedicine-glossary (last visited May 3, 2017).

[2] See, e.g., David Pittman, Texas Two-Step on Telemedicine, POLITICO (May 9, 2017), http://www.politico.com/tipsheets/morning-ehealth/2017/05/senate-acts-on-fda-items-220211.

[3] Latoya Thomas & Gary Capistrant, American Telemedicine Association, State Telemedicine Gaps Analysis: Physician Practice Standards & Licensure at 75 (February 2017) [hereinafter, "ATA Physician Practice Standards & Licensure Survey"].

On a related note, healthcare practitioners should verify and document the geographic location of patients when providing services via telemedicine to avoid unlicensed practice issues associated with any potential miscommunication concerning the particular state in which the patient is located at the time of the telemedicine encounter. Healthcare practitioners should also consider whether they are required to be licensed in the state where they are located at the time of telemedicine encounters, even if they are providing services to a patient in a separate state, under the law of their home state, or pursuant to payor requirements.

[4] Ga. Code Ann. § 43-34-31. See also, Tenn. Code Ann. § 63-6-231.

[5] W. Va. Code 30-3-13(b).

[6] Ga. Code Ann. § 43-34-31(b).

[7] ATA Physician Practice Standards & Licensure Survey at 11.

[8] Id. At 81. See, e.g. 32 Maine Rev. Stat. § 3300-D; Minn. Stat. § 147.032. As another example, Tennessee, until recently, issued what were referred to as "telemedicine licenses." Although physicians previously granted such

licenses may continue to renew such licenses or convert them to full licenses, the state has phased out the issuance of such limited licenses. Tenn. Comp. R. & Regs. R. 0880-02-.16(2). Even if already licensed in a state in which a healthcare practitioner will be treating patients, the healthcare practitioner should check for additional licensure or registration requirements.

[9] Similarly, you should review applicable state requirements for other types of healthcare practitioners. As an additional note, physicians engaged in teleradiology should not assume that telemedicine and teleradiology regulations in a particular state are coextensive or that requirements are the same. For example, Hawaii has a radiology-specific licensure provision that should be consulted in addition to telemedicine provisions. Haw. Rev. Stat. §§ 453-1.3; 453-2(b)(7).

[10] Tenn. Code Ann. § 63-1-155; Tenn. Comp. R. & Regs. R. 0880-02-.16(1)(d).

[11] Arkansas State Medical Board Regulations 2.8 and 38; Ga. Comp. R. & Regs. R. 360-3-.07.

[12] Ga. Comp. R. & Regs. R. 360-3-.07(a)(8).

[13] 22 Tex. Admin. Code § 174.7. Texas's telemedicine requirements will likely soon change pursuant to a bill (S.B. 1107) just passed by the Texas Legislature at the time of this writing.

[14] 22 Tex. Admin. Code §§ 174.6 and 174.7.

[15] Tenn. Comp. R. & Regs. R. 0880-02-.16.

[16] Ariz. Rev. Stat. § 36-3602. See, also Cal. Bus. & Prof. Code § 2290.5(b) and ATA Physician Practice Standards & Licensure Survey 4, 5 and 69.

[17] Tenn. Comp. R. & Regs. R. 0880-02-.16(1)(g).

[18] Id. at 0880-02-.16(6)(a).

[19] Id. at 0880-02-.16(1)(g).

[20] Ind. Code § 25-1-9.5-6.

[21] 22 Tex. Admin. Code § 174.8.

[22] Healthcare practitioners should also be aware that state Medicaid and/or state telemedicine "parity" laws for insurance may add another layer of requirements with respect to technology that is required or what forms of electronic interaction do not constitute "telemedicine" for purposes of coverage.

In addition to any requirements concerning documentation of informed consent, healthcare practitioners should be aware of any other documentation-related requirements that may exist. For example, in addition to the need to document patient identity and location, healthcare practitioners may be required to obtain medical histories, document the telemedicine encounter in the patient's medical record, state the technology used in the telemedicine encounter and/or make documentation available to the patient. See, e.g., Haw. Rev. Stat. § 453-1.4; Ind. Code § 25-1-9.5-7; Tenn. Comp. R. & Regs. R. 0880-02-.16(6). In some states, physicians who use email for patient communications are required to have policies governing privacy/confidentiality, hours of operation, and other matters. 844 Ind. Admin. Code 5-3-4; 22 Tex. Admin. Code § 174.9.

[23] 21 U.S.C. § 829(e); 21 U.S.C. 802(54)(A).

[24] At some point in the near future, the DEA is expected to issue a rule pursuant to which practitioners with a special telemedicine registration from the DEA could prescribe controlled substances in certain circumstances without an in-person medical evaluation. Healthcare practitioners should also consider all applicable requirements under the DEA's Electronic Prescriptions for Controlled Substances Final Rule before conducting any e-prescribing activities. 75 Fed. Reg. 16236 (Mar. 31, 2010).

[25] Ga. Comp. R. & Regs. r. 360-3-.02(6). Although Tennessee regulations on physician electronic prescribing do not necessarily preclude electronic prescribing in connection with telemedicine in some instances, the requirements in place do apply to all drugs, and not just to controlled substances. Tenn. Comp. R. & Regs. R. 0880-02-.14(6) and (7).

[26] A host of states also have provisions that bar prescribing based only on a telephone conversation or a questionnaire. Ark. Code Ann. § 17-92-1004(c); Haw. Rev. Stat. § 453-1.3; Fla. Admin. Code Ann. 64B8-9.0141(4), (6) and (6); Tenn. Comp. R. & Regs. R. 0880-02-.14(7)(c).

See, e.g., Tenn. Code. Ann. §§ 63-6-201 et seq., 68-11-205 et seq. 48-101-601 et seq. and 48-249-1101 et seq.

[27] Tenn. Code. Ann. § 63-6-225.

[28] This overview does not address the telemedicine policies and requirements of every type of payor program, including state employee health plans, state Children's Health Insurance Plans (CHIP) or the US Department of Defense (TRICARE and similar benefits). The policies and requirements of these additional programs should be considered if relevant.

[29] For a full list, see Department of Health and Human Services, Centers for Medicare and Medicaid Services,

Medicare Learning Network: Telehealth Services (ICN 901705; Nov. 2016). For all services furnished after January 1, 2017, distant site providers use place of service code POS 02.

Telemedicine services are not separately reimbursed under the inpatient and outpatient payment systems, among others, although telemedicine services are permitted (and reimbursed) under those payment systems. MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, Chapter 8, pg. 237 (June 2016). Notably, Medicare has hospital conditions of participation ("CoPs") with respect to telemedicine. 42 C.F.R. § 482.1 et seq.

[30] Id. But note that asynchronous "store and forward" technology is permitted in federal demonstration programs in Alaska or Hawaii (assign the GQ modifier). Although not covered as "telemedicine services" under Medicare, remote monitoring, teleradiology and certain other services are payable under Medicare outside of the "telemedicine" category (and different requirements apply).

[31] Id. See also, US Government Accountability Office Report to Congress, Health Care: Telehealth and Remote Patient Monitoring Use in Medicare and Selected Federal Programs, 8 (Apr. 2017). As further discussed on page 34 of this report, clients of HBMA members will likely also want to be aware that providers can use telemedicine to meet certain criteria in the improvement activities performance category under the Merit-Based Incentive Payment System (MIPS), even if providers do not bill for the services, although providers must meet Medicare's telemedicine requirements if they choose to bill for telemedicine services.

[32] Id. See HCPCS code Q3014.

[33] Id.

[34] The Centers for Medicare and Medicaid Services ("CMS") provides a Medicare Telehealth Payment Eligibility Analyzer that can be used to help determine whether a particular site meets the eligibility criteria. Id.

[35] MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, Chapter 8, pg. 243 (June 2016).

[36] Id.

[37] Id.

[38] Id. at 238-39.

[39] Id.

[40] United States Government Accountability Office Report to Congress, Health Care: Telehealth and Remote Patient Monitoring Use in Medicare and Selected Federal Programs, 9-10 (Apr. 2017). Notably, however, states need not submit a separate state plan amendment with respect to telemedicine if they choose to pay for telemedicine in the same manner as face-to-face services.

[41] MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, Chapter 8, pg. 250 (June 2016). MedPAC also provided detailed findings with respect to Medicaid program requirements, as of the date of its report. 43 programs covered telehealth without geographic limitations (i.e., facility and/or rural-only limitations), with 36 programs even recognizing the patient's home as a valid originating site. Twenty-nine programs reimbursed the originating site for service while all reimbursed the distant site. Nine programs had no restrictions on the types of medical services provided through telehealth, while 40 programs, unsurprisingly, had such restrictions. Thirty-four programs restricted the types of providers allowed to provide serves through telehealth. Forty-eight programs offered reimbursement for two-way video, 9 programs reimbursed for the use of store-and-forward technology, and 16 states reimbursed for remote patient monitoring by some types of providers and for some types of clinical conditions. For additional helpful data, see Latoya Thomas & Gary Capistrant, American Telemedicine Association, State Telemedicine Gaps Analysis: Coverage & Reimbursement at 75 (February 2017).

[42] Id.

[43] Tenn. Code Ann. § 56-7-1002.

[44] Id.

[45] Latoya Thomas & Gary Capistrant, American Telemedicine Association, State Telemedicine Gaps Analysis: Coverage & Reimbursement at 8-9 (February 2017).

[46] In its 2016 report, MedPAC made several interesting observations with respect to coverage of telemedicine by commercial insurers. It observed that insurers tend to focus telemedicine coverage on basic medical care, especially after-hours care. It also indicated that although sources it has consulted suggest that insurers are expanding coverage of telehealth services, "there has [recently] been little evidence of an increase in telehealth utilization in insurers' claims data." MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, Chapter 8, pg. 246 (June 2016).