# Health Law Webinar

## Telehealth and Virtual Care in the Time of COVID-19: Current Status and Questions about the Future

September 16, 2020

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# Today's Webinar

- Telemedicine Overview
- Key Legal Issues
- Key Contracting Issues
- Due Diligence Considerations
- Future of Telehealth
- Q&A

# What is telemedicine?

Telemedicine is the use of electronic communication technologies to provide clinical services to patients without an in-person visit, with the goal of improving the patient's health status. The electronic communications or monitoring may be used for follow-up visits, management of chronic conditions, medication management, consultation with specialists, or other clinical services that can be provided remotely via secure video and audio connections.

# How does telemedicine fit into the digital health ecosystem?

# Digital Health Broadly

Health Apps

Connected Devices / IoT


Automation and Robotics

Consumer apps and wearables


Clinical Research

Health IT / Services

Telemedicine

Medical Algorithms

# Types of Telemedicine

- Store-and-Forward (Asynchronous)
- Remote Patient Monitoring
- Real Time Services

# Store-and-Forward (Asynchronous)

- The electronic transmission of patient data among providers at different locations
- A secure way to share information
- Asynchronous – providers do not need to be reviewing the patient records at the same time
- Best suited for consulting with specialists, external resources
- Examples:
  - Teleradiology – a smaller facility can send x-rays to a remote radiologist for review and diagnosis
  - Teledermatology – a primary care physician can take a picture of a skin condition and send to a specialist for consultation
  - E-Consults, second opinions
- Benefits:
  - Patients can obtain specialty care, even if not available in their particular geography
  - Faster, more cost-effective than seeing a specialist

# Remote Patient Monitoring

- The collection of health data from a patient in one location, and the transmission of the health data to a provider in a different location
- Can be done with active and live monitoring of information to flag for issues
- Alternatively, providers can receive reports of collated data for better ongoing care
- Often used for chronic care management
- Examples:
  - Monitoring vitals, blood pressure, glucose levels, heart rate, pulse, sleep patterns, weight
  - Information often gathered from wearable and mobile devices
  - Tele-hospitalist, tele-cardiology
- Benefits:
  - Can help identify issues quickly before they develop into bigger problems
  - Can help providers better understand patient behavior
- Risks:
  - Wearable devices – new, unproven applications

# Real Time Services

- Live, two-way video encounter between a patient and a provider, or between providers
- “Skype” medicine – but with secure, private connections and HIPAA compliant technology
- Most often used for primary care, urgent care or follow-up issues
- Examples:
  - Patients with suspected pink eye, ear infection, influenza, rash, respiratory infections, lice
  - Tele-Neuro (strokes, sepsis, cardiology)
- Benefits:
  - Convenient, fast, cost-effective for patients
  - Opportunity to get immediate treatment
  - Not limited to physicians in your immediate area
- Risks:
  - Managing patients from distant locations

# Sample Business Models

- Traditional Providers
- Technology Companies (equipment and software)
- Telemedicine Companies

# Types of Telemedicine Agreements

- Telemedicine Services Agreement
- Credentialing and Privileging Agreement
- Equipment Lease or Purchase Agreement
- Technology or Software Licensing or Purchase Agreement
- Technology Service Agreement
- Data Use Agreement
- Business Associate Agreement
- Management Services Agreement
- Collaborative or Supervising Agreement
- Website Terms of Use and Privacy Policy

# Legal Issues

- Licensure
- Scope of Practice
- Prescribing
- Reimbursement
- Fraud and Abuse
- Informed Consent
- Privacy and Security
- Consumer Protection Laws
- Contract Provisions and Risk Mitigation
- Corporate Practice of Medicine

# Telehealth

- Before COVID-19 (B.C.)
- COVID-19 Era (C.E.)
- After COVID-19 (A.C.)

# Background

- Government officials slow to embrace telehealth
  - License portability
  - Interstate licensure
  - Online prescribing
  - Scope of practice
  - Establishing physician/patient relationship

# COVID Changes Everything

# What is the state of telemedicine?

- There are many layers
  - Medicare
  - Medicaid
  - Commercial reimbursement
  - Federal and state declared emergencies
  - State licensure requirements
  - Prescribing controlled substances (and other drugs)

# What is the status of the federal public health emergency?

- While extended July 25, 2020, that does NOT guarantee another 90 days of emergency!
- “It’s over when I say it’s over…”
- The 2021 Medicare physician fee schedule may be an attempt to help with SOME of the issues

# May I perform a virtual visit for a patient in a state where I am not licensed?

- The answer has always been, and still is, “It depends.”
- Look to the licensing laws of the state where the patient is located
- There are 51 (x the number of different licensed practitioners) licensure schemes to navigate

# COVID-19 has made this a bit easier…Kind of.

- Many states have, minimally, eased licensure requirements for out-of-state practitioners providing virtual care to patients in the state
  - E.g., no requirement if fully licensed and in good standing in another state; registration only; temporary application process; expedited approval; exception for COVID-19 related treatment; and every other variant
- However, state licensure waivers may have ended, may be extended, or may now be permanent

# If the answer is not clear, what factors mitigate the risk?

- Insurance coverage – yours and the patient's
- Established patient versus new
- Prescribing versus no prescription
- Frequent versus occasional
- Temporarily in the state versus permanently
- Patient's condition – acuity, ability to handle problem via virtual treatment

# Telemedicine and Prescribing

- Most prescribing statutes were written before widespread use of telemedicine
- State statutes are vague
- Many states require a physical exam or pre-existing physician-patient relationship prior to prescribing (some require this for controlled substances and others for non-controlled)

# Telemedicine and Prescribing

Minn. Stat. 157.37 (d) A prescription drug order for [controlled substances and certain other drugs] is not valid, unless it can be established that the prescription drug order was based on a documented patient evaluation, including an examination, adequate to establish a diagnosis and identify underlying conditions and contraindications to treatment:

(e) For the purposes of paragraph (d), the requirement for an examination shall be met if an in-person examination has been completed in any of the following circumstances:

...

(5) the referring practitioner has performed an examination in the case of a consultant practitioner issuing a prescription or drug order when providing services by means of telemedicine.

# Telemedicine and Prescribing

- Federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008 – designed to combat rogue internet pharmacies selling controlled substances online
  - Prohibited form-only online prescribing for controlled substances
  - Permitted prescribing of controlled substances via telemedicine if practitioner has conducted an in-person exam or meets a “practice of telemedicine” exception (limited to hospitals, another registrant in the room, etc.); does not allow prescribing for individuals at home or at work during the visit
  - There is an exception for prescribers with a “special registration” under rules to be promulgated by the DEA
  - There is a public health emergency exception…

# Telemedicine and Prescribing

- 2018 SUPPORT Act included the “Special Registration for Telemedicine Act of 2018” requiring DEA to promulgate special registration regulations by October 24, 2019
- November 22, 2019: Justice Department announced plans to issue a proposed rule on special registration requirements
- Still awaiting issuance…

# Enter COVID-19

- On March 16, 2020, the DEA authorized, for the duration of the PHE, telemedicine prescribing of scheduled II-V controlled substances without a previous in-person exam, if all of the following are met:
  - The Rx is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
  - The telemedicine communication is conducted using audio-visual, real-time, two-way interactive communication system; and
  - The practitioner is acting in accordance with applicable federal and state law.

# Medicare's "Telehealth" Evolution

- Buckle up
- The policy is good, but the execution is a bit complicated at times

# Pre-COVID-19

- Prior to COVID-19, Medicare coverage of “telehealth” was limited:
  - Treatment via “**audio/visual, interactive, real-time telecommunication technology**” (distinguishable from Communication Technology-Based Services (“CTBS”));
  - Discrete set of codes (i.e., the “telehealth” codes);
  - Limited set of patient locations (facility, rural); and
  - Only statutorily authorized practitioners may perform.
- Originating site facility fee + professional fee; Place of Service code 02

# Originating Site Expansion

- As of March 6, 2020, CMS will pay for “telehealth” (and CTBS) wherever the patient is located, including the patient’s residence
- “Telehealth” and CTBS are still defined by code

# Expansion of "Telehealth" Codes During COVID-19

- There is still a "telehealth" code list
  - https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
  - Codes will be added, and list will be modified, on a "sub-regulatory basis"
- Unless indicated otherwise, a "telehealth" code must still be furnished using "audio and video equipment permitting two-way, real-time interactive communication"

# “Telehealth” Allowed For

- Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
- Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217-99220; 99224-99226; 99234-99236)
- Initial Hospital Care and Hospital Discharge Day Management (CPT codes 99221-99223; 99238-99239)

# “Telehealth” Allowed For

- Initial Nursing Facility Visits, All Levels (Low, Moderate, and High Complexity) and Nursing Facility Discharge Day Management (CPT codes 99304-99306; 99315-99316)
- Critical Care Services (CPT codes 99291-99292)
- Domiciliary, Rest Home, or Custodial Care Services, New and Established (CPT codes 99327-99328; 99334-99337)

# “Telehealth” Allowed For

- Home Visits, New and Established, All Levels (CPT codes 99341-99345; 99347-99350)
- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468-99473; 99475-99476)
- Initial and Continuing Intensive Care Services (CPT codes 99477-994780)
- Care Planning for Patients with Cognitive Impairment (CPT code 99483)

# “Telehealth” Allowed For

- Group Psychotherapy (CPT code 90853)
- Psychological and Neuropsychological Testing (CPT codes 96130-96133; 96136-96139)
- Radiation Treatment Management Services (CPT codes 77427)

# “Telehealth” Allowed For

- End-Stage Renal Disease Services (CPT codes 90952-90953; 90959; 90962)*

  * “For Medicare patients with ESRD, we are exercising enforcement discretion on the following requirement so that clinicians can provide this service via telehealth: individuals must receive a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial 3 months of home dialysis and at least once every 3 consecutive months after the initial 3 months.”

# “Telehealth” Allowed For

- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-68; 97110, 97112, 97116, 97535, 97750, 97755, 97760-61, 92521-24, 92507)

# Therapy and “Telehealth”

- Physical therapists, occupational therapists, and speech-language pathologists are not statutorily authorized to provide “telehealth”
- But CMS is "letting them do telehealth for approved PT/OT/SLP codes. “¯_(ツ)_/¯”

# Expansion of Who May Perform "Telehealth"

"CMS is waiving the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands 8/20/2020 1 the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. As a result, a broader range of practitioners, such as physical therapists, occupational therapists, and speech language pathologists can use telehealth to provide many Medicare services."

# Place of Service for Telehealth

- Practitioners providing expanded telehealth services should report the POS code that would have been reported if the service was furnished in person
- CMS is assuming the costs of services typically incurred by the originating site are, during COVID-19, incurred by the practitioner furnishing telehealth as if the visit was in-person)

# What about telehealth services provided to a hospital outpatient?

- This is a brain teaser

# COVID-19 Flexibilities

- During the PHE, three categories of outpatient services may be provided as if the patient's home is a hospital provider-based department (PBD):
  - (1) hospital outpatient therapy, education, and training services, including PHP services, that can be furnished remotely; (2) hospital outpatient clinical staff services furnished in-person to the beneficiary; and (3) hospital services associated with a professional service delivered by telehealth.

# But first you have to relocate the PBD to the patient's home

- Background: Services provided at off-campus provider-based departments established on or after November 2, 2015, are paid at Physician Fee Schedule rate. On-campus and "excepted" off-campus PBDs are paid under the OPPS

# Temporary "Extraordinary Circumstances" Relocation Policy

- During the PHE, on-campus PBDs (or "excepted" off-campus PBDs) that temporarily relocate off-campus—**including to the patient's home**—during the PHE for purposes of addressing COVID-19 will still be "excepted" – i.e., paid under the OPPS – if the relocation is not inconsistent with the state pandemic plan

# Process for Temporary Relocation

- No enrollment update required (if PBD services are billed under the main hospital);
- May begin furnishing and billing under the OPPS in the new location prior to notifying the Regional Office (RO);
- Use modifier “PO” for OPPS claims; and
- Notify the RO by email of the relocation.

# Notification to the Regional Office

- Email notification should include (i) hospital CCN; (ii) addresses of current and relocated PBD; (iii) start date of services at relocated PBD; (iv) brief justification for relocation and role of relocation in hospital's response to COVID-19; (v) why the location is appropriate for outpatient services; and (vi) attestation the relocation is not inconsistent with state emergency/pandemic plan

# Relocation of PBD to the Patient's Home

- During the PHE, a hospital may relocate to an off-campus PBD that is otherwise the patient's home: i.e., it may register and treat outpatients at their homes (for some services)
- CMS has clarified that hospitals must submit the address of each patient to whose home the PBD is relocated
  - Bummer

**Question:** Under the new process to seek an extraordinary circumstances relocation exception that is in place during the COVID-19 PHE, do hospitals need to submit a relocation request for *every* location to which its PBD relocates, including in circumstances where the excepted PBD relocates to several different patients' homes?

**Answer:** Hospitals have 120 days from the date on which they begin furnishing services at a relocated PBD to submit a temporary extraordinary circumstances relocation exception request (85 FR 27561). As part of a relocation exception request, hospitals should notify their CMS Regional Office by email of the addresses of the locations to which its PBD relocates. Hospitals are not required to submit a separate email for every relocation site. Hospitals can send a request that includes all of the addresses to which the PBD relocated over a period of weeks or months, rather than a single request for each location. The hospital should also notify the Regional Office of the addresses of any patients' homes to which the PBD relocates if the hospital intends to be paid under the OPPS for these services. If a hospital chooses not to submit a patient's home address for an extraordinary circumstances relocation request, the hospital can simply bill for services provided at such relocation site with the "PN" modifier and receive payment at the PFS-equivalent rate for those services.

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

# So What About Outpatient Telehealth Visits?

- Do you bill Q3014 or as if it is an in-person visit at a hospital outpatient department (G0463)?
- Query: Where is the professional located?
- If the physician and the patient are both “in the hospital” then bill is as an in-person hospital outpatient visit (G0463)

**Question**: For services furnished to patients in a provider-based department of the hospital (which may include the patient's home during the COVID-19 PHE), when can a hospital bill for the clinic visit code (G0463, "Hospital outpatient clinic visit") and when can a hospital bill for the originating site facility fee (Q3014)?

**Answer**: We remind readers that the provider should bill using the HCPCS code that describes the service(s) that were furnished. The following information may help hospitals determine appropriate billing.

- If a distant site practitioner furnishes a telehealth service to a registered hospital outpatient, and hospital staff provide administrative and clinical support, the hospital may bill for the originating site facility fee (Q3014). It would not be appropriate for the hospital to bill HCPCS code G0463 in this situation.
- HCPCS code G0463 describes a clinic visit furnished in the hospital outpatient setting when the practitioner and the patient are both located within the hospital. Typically, the hospital would bill G0463 when a professional is located in the hospital and furnishes an evaluation and management outpatient service to a hospital outpatient who is also in the hospital. If a physician is practicing from a hospital that has registered the patient as a hospital outpatient in the patient's home, which is serving as a provider-based department of the hospital, we consider the physician and patient to be "in the hospital" and usual hospital outpatient billing rules would apply in terms of billing for the service(s) furnished. In this situation, there is no distant site practitioner and no telehealth service being furnished.

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

# Telephone E&M Services

- What if my patient doesn't have a smart phone?
- When performing an E&M that would otherwise be reported as in-person or a "telehealth" visit, if using audio-only (i.e., the dumb phone), bill using the telephone E&M codes (CPT 99441-99443)
  - Effective March 1, 2020 and during the PHE, Medicare will pay equivalent to the Medicare payment for office/outpatient visits with established patients

# Remote Evaluations, Virtual Check-Ins and E-visits

- Remote evaluation of patient video/images (G2010)
- Virtual check-in (G2012)
- E-visit (G2061-63)

# Remote Evaluations, Virtual Check-Ins and E-visits

- During the PHE, remote evaluations and virtual check-ins may be provided to new patients (pre-COVID restricted to established patients)
- During the PHE, remote evaluations, virtual check-ins, and e-visits may be performed by PTs, OTs, SLPs, LCSWs and psychologists

# Remote Patient Monitoring

- What is it? Collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted to the practitioner (CPT 99453-54, 99457-58)
- Medicare pays a small amount for initial enrollment into RPM pogrom and a monthly base payment for device management and patient readings

# Remote Patient Monitoring

- Permanent change: RPM now covered for patients who have acute (not just chronic) conditions and patients with only one disease
- Temporary change during the PHE: RPM may be provided to new (not just established) patients

# Other Remote Services Permitted During the PHE

- “Direct supervision” may be provided virtually using real-time, two-way A/V technology (diagnostic tests; outpatient therapeutic services)
- “Incident to” supervision may be virtual
- Teaching physicians may supervise residents remotely using real-time, two-way A/V technology
- Therapy and counseling in OTPs may be provided by telephone if patient does not have access to real-time, two-way A/V technology

# State Law Waived for Medicare…?

"CMS waives the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which s/he is practicing for individuals for whom the following four conditions are met: 1) must be enrolled as such in the Medicare program, 2) must possess a valid license to practice in the State which relates to his or her Medicare enrollment, 3) is furnishing services – whether in person or via telehealth – in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity, and 4) is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area. A physician or non-physician practitioner may seek an 1135-based licensure waiver from CMS by contacting the provider enrollment hotline for the Medicare Administrative Contractor that services their geographic area. This waiver does not have the effect of waiving State or local licensure requirements or any requirement specified by the State or a local government as a condition for waiving its licensure requirements."
https://www.cms.gov/files/document/covid19-emergency-declaration-health-car-providers-fact-sheet.pdf

# Medicare Proposals for 2021

- CMS proposes some permanent additions to the “telehealth” list beginning 1-1-2021
- CMS is also evaluating what services added to the “telehealth” list during the PHE would remain on the list as “Category 3 temporary services” through the calendar year in which the PHE ends

# Proposed Permanent Telehealth Additions

- Care Planning for Patients with Cognitive Impairment HCPCS Codes 99483;
- Domiciliary, Rest Home, or Custodial Care services HCPCS Code 99334 and 99335;
- Group Psychotherapy HCPCS Code 90853;
- Home Visits HCPCS Codes 99347 and 99348;
- Neurobehavioral Status Exam HCPCS Code 96121;
- Prolonged Services HCPCS Code 99XXX; and
- Visit Complexity Associated with Certain Office/Outpatient E/Ms HCPCS Code GPC1X.

# Proposed Temporary Additions to Telehealth List

- Domiciliary, Rest Home, or Custodial Care services, Established patients HCPCS Codes 99336 and 99337;
- ED Visits HCPCS Codes 99281, 99282, and 99283;
- Home Visits, Established Patient HCPCS Codes 99349 and 99350;
- Nursing facilities discharge day management HCPCS Codes 99315 and 99316; and
- Psychological and Neuropsychological Testing HCPCS Codes 96130, 96131, and 96132, and 96133.

# What's Left Off After the PHE?

- Initial and final/discharge interactions (CPT codes 99234–99236 and 99238–99239);
- Higher level emergency department visits (CPT codes 99284–99285); and
- Hospital, Intensive Care Unit, Emergency care, Observation stays (CPT 99217–99220; 99221–99226; 99484–99485, 99468–99472, 99475–99476, and 99477–99480).

# Other 2021 Proposals

- RPM would be for only established patients after end of PHE;
- Only practitioners who may provide E&M services may bill Medicare for RPM; and
- RPM may be provided to patients with acute as well as chronic conditions.

# Other 2021 Proposals

- Telehealth rules would not apply to services provided by real-time, A/V technology when they're in the same location as the patient (e.g., clinician uses the technology to avoid exposure to potential COVID-19 patient);
- Permit direct supervision to be provided via real-time, A/V technology through December 31, 2021.

# Types of Agreements/Contract Considerations

- Telemedicine Services Agreement
- Credentialing and Privileging Agreement
- Equipment Lease or Purchase Agreement
- Technology or Software Licensing or Purchase Agreement
- Technology Service Agreement
- Data Use Agreement
- Business Associate Agreement
- Management Services Agreement
- Collaborative or Supervising Agreement
- Website Terms of Use and Privacy Policy

# Agreement for Services

- Understand applicable telemedicine practice standards (scope of practice, prescriptive authority, licensure, etc.)
- Confirm arrangement complies with those requirements.
  - Services provided, types of providers, locations
- Support Services (training, clinical protocols, maintenance of licenses, etc.)
- Anticipating Changes to Rules and Regulations
  - Fundamental Regulatory Change Provisions
  - Changes to Licensure/Scope of Practice

# Equipment and Technology Agreements

- Purchasing, installation and maintenance
- Access to support services, technology updates, what to do if technology goes down
- Education and training
- Licensing terms
- Interoperability
- Other terms: support services, technology updates, representations and warranties, etc.
- Federal and state requirements

# Intellectual Property and Data

- Ownership
- Use
- Confidential Information

# Reimbursement and Compensation

- Reimbursement
  - Understand state, federal, and commercial reimbursement and billing rules and regs
    - Who is billing and collecting for the telemedicine?
    - Government Payors?
    - Commercial Payers
    - Billing and Coding
- Compensation
  - Ensure compensation covers all aspects of the arrangement
  - Analyze compensation arrangements for compliance with fraud and abuse laws

# Fee-Splitting and Fraud and Abuse

# Fee-Splitting

- Many states prohibit fee-splitting
  - Perceived danger of allowing professionals and non-professionals to share in income from professional services:
    - Temptation to maximize profit through medically unnecessary services.
    - Temptation to limit medically necessary services to maximize income.

# Corporate Practice of Medicine

- Corporate practice doctrine prohibits corporations from employing certain licensed clinical professionals or owning/controlling medical practices
- Intended to prevent lay persons from exerting control or influence over physician medical decision-making.
- Corporate practice restrictions are based in state statute, case law, AG opinions, board policies, etc.

- The applicability varies state by state, and by provider type:
  - Physicians
  - Nurses
  - Mental/Behavioral Health Providers
  - Physical Therapy
- States vary in the exceptions to the state corporate practice prohibitions:
  - Hospitals
  - Professional entities
  - Insurers
- Enforcement varies from state to state

# Federal Anti-Kickback Statute

- Prohibits offering, paying, soliciting or receiving any remuneration in return for
  - Business for which payment may be made under a federal health care program; or
  - Inducing purchases, leases, orders or arranging for any good or service or item paid for by a federal health care program
- Remuneration includes kickbacks, bribes and rebates, cash or in kind, direct or indirect

# Federal Anti-Kickback Statute

- Potential penalties for violations of anti-kickback statute:
  - Criminal and civil penalties
  - Imprisonment
  - Civil Monetary Penalties
  - False Claims Act exposure

# Federal Anti-Kickback Statute

- Telemedicine relationships requiring anti-kickback analysis:
  - Relationships with supervising/collaborating physicians
  - Relationships with other entities (management company, telemedicine entity, equipment/technology vendor, etc.)

# Federal Anti-Kickback Statute

- Risk mitigation
  - Exclude certain payors
  - Safe harbor protection
    - Space rental, equipment rental, personal services and management contracts, etc.
    - Advisory opinions
    - Remember state law

# Self-Referral Prohibitions

- Federal Stark law prohibits a physician from making a referral for designated health services ("DHS") to an entity with which the physician (or an immediate family member) has a financial relationship, unless one of its many exceptions applies.
- Stark also prohibits entities from submitting claims for DHS provided pursuant to a prohibited referral.

# Self-Referral Prohibitions

- Stark is a strict liability statute, meaning that the intent of the parties is irrelevant for purposes of determining whether the law has been violated.
- Stark provides for monetary penalties and requires the refund of amounts paid for illegally referred DHS.

# Self-Referral

- Telemedicine relationships requiring self-referral analysis:
  - Arrangements that involve free/discounted equipment or services, volume discounts, “per-click” payments, or advertisements should be analyzed for possible self-referral issues

# Self-Referral

- Exclude certain payors/types of services
- Limit ownership
- Exceptions
- Waivers
- Remember state law

# Due Diligence Considerations

- Compliance
- Intellectual Property
- Data Sources and Rights
- Specific Software Issues
- Information Technology
- Additional Considerations

# Forecast

# Presenters

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