Medicare Telehealth Reimbursement Information

Medicare Coverage of Telemedicine/Telehealth Services

Medicare reimbursement for telemedicine or telehealth services is divided into three areas:
1. Remote patient face-to-face services seen via live video conferencing
2. Non face-to-face services that can be conducted either through live video conferencing or via store and forward telecommunication services
3. Home telehealth services

1. Remote Patient Face-To-Face, Interactive Services

The Centers for Medicare & Medicaid Services (CMS) defines telehealth services to include those services that require a face-to-face meeting with the patient (store and forward is excluded). Such reimbursement is limited to the type of services provided, geographic location, type of institution delivering the services and type of health provider.

Facility Location

The service must be provided to an eligible Medicare beneficiary in an eligible facility (originating site) located outside of a metropolitan area. However, there is no limitation on the location of the health professional delivering the medical service (referring site).

Eligible Medical Services

Services that are eligible for reimbursement include consultation, office visits, individual Psychotherapy, and pharmacologic management delivered via a telecommunications system. The official CMS policy reads as follows:

"The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy and pharmacologic management. These services and corresponding current procedural terminology (CPT) codes are listed below.

- Consultations (CPT codes 99241 - 99275)
- Office or other outpatient visits (CPT codes 99201 - 99215)
- Individual psychotherapy (CPT codes 90804 - 90809)
- Pharmacologic management (CPT code 90862)
- Psychiatric diagnostic interview examination (CPT code 90801) (Effective March1, 2003)
- End stage renal disease related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318).
- Individual Medical Nutrition Therapy (HCPCS codes G0270, 97802, and 97803). (Effective January 1, 2006).

Eligible Providers

Only the following health professionals may claim reimbursement for remote telehealth Services:

- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Clinical nurse specialist
- Clinical psychologist*
- Clinical social worker*
- Registered dietitian or nutrition professional
- * Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.

Eligible Facilities

The following facilities are eligible to be an originating site:

- The office of a physician or practitioner
- A hospital
- A critical access hospital
- A rural health clinic
- A federally qualified health center

Reimbursement Amounts

Reimbursement to the health professional delivering the medical service is the same as the current fee schedule amount for the service provided. In addition, the nonmetropolitanfacility with the patient is eligible to receive a facility fee. Claims for reimbursement should be submitted with the appropriate CPT code for the professional service provided and the telehealth modifier “GT” – “via interactive audio and video telecommunications system."

Claims submission

Claims for professional consultations, office visits, individual psychotherapy, and pharmacologic management provided via a telecommunications system are submitted to the carrier that processes claims for the performing physician/practitioner's service area. Physicians/practitioners submit the appropriate CPT procedure code for covered professional telehealth services along with the "GT" modifier ("via interactive audio and video telecommunications system"). By coding and billing the "GT" modifier with a

covered telehealth procedure code, the distant site physician/practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished.

To claim the facility payment, physicians/practitioners will bill HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." The type of service for the telehealth originating site facility fee is "9, other items and services." For carrier processed claims, the "office" place of service (code 11) is the only payable setting for code Q3014. There is no participation payment differential for code Q3014 and it is not priced off of the Medicare Physician Fee Schedule Database file. Deductible and coinsurance rules apply to Q3014. By submitting HCPCS code "Q3014", the biller certifies that the originating site is located in either a rural HPSA or a non-MSA county. Physicians and practitioners at the distant site bill their local Medicare carrier for covered telehealth services, for example, "99245 GT". Physicians' and practitioners' offices serving as a telehealth originating site bill their local Medicare carrier for the originating site facility fee.

Store and Forward Exception

Federal demonstration programs providing telemedical services in Alaska and Hawaii have also been granted the authority to bill Medicare for normal face-to-face services that use store and forward telemedicine.

2. Remote Non Face-to-Face Services

Services delivered using telecommunications technology but not requiring the patient to be present during their implementation are covered the same as services delivered when on-site at the medical facility.

"A service may be considered to be a physician's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of x-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc.

For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram reading that has been transmitted via telephone (i.e., electronically rather than by means of a verbal description) is a covered service."
These remote services are NOT considered "telehealth" or "telemedicine" by CMS. Rather, they are considered the same as services delivered on-site and are to be coded and will be paid in the same way. There are no geographic or facility limitations on these services.

The largest single specialty providing remote services under this policy is radiology. However, the use of telecommunications in delivering pathology, cardiology, physician team conferences and other services are also covered. Special CPT Codes are used for the remote assessment of pacemakers as well as the collection and assessment of data from cardiac event recorders.

3. Home Telehealth

Section 1895(e) of the Act states that telehealth services are outside the scope of the Medicare home health benefit and home health prospective payment system (PPS). This provision does not provide coverage or payment for Medicare home health services provided via a telecommunications system. The law does not permit the substitution or use of a telecommunications system to provide any covered home health services paid under the
home health PPS, or any covered home health service paid outside of the home health PPS. As stated in 42 CFR 409.48(c), a visit is an episode of personal contact with the beneficiary by staff of the home health agency (HHA), or others under arrangements with the HHA for the purposes of providing a covered service.

However, this provision clarifies that there is nothing to preclude a home health agency from adopting telemedicine or other technologies that they believe promote efficiencies, but that those technologies will not be specifically recognized or reimbursed by Medicare under the home health benefit.