



American Telemedicine Association

TELEMEDICINE AND TELEHEALTH SERVICES

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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

In addition, national and local coverage determinations may alter or expand the services that are eligible for reimbursement.

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

The Centers for Medicare and Medicaid Services (CMS) defines telehealth services to include those services that require a face-to-face meeting with the patient. Reimbursement for these services was initiated through Congressional legislation. Such reimbursement is limited to the type of services provided, geographic location, type of institution delivering the services and type of health provider.

Location of Facility

The service must be provided to an eligible Medicare beneficiary in an eligible facility (originating site) located outside of a Metropolitan Statistical Area (State-specific maps of Metropolitan Statistical Areas are at http://www.census.gov/geo/www/maps/stcbsa_pg/stBased_200411_nov.htm). 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 use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy and pharmacologic management.

The 2013 list of Medicare telehealth covered services is (by CPT or HCPCS codes)—

- 90791 and 90792: Psychiatric diagnostic interview examination
- 90832 – 90834 and 90836 – 90838: Individual psychotherapy
- 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961: End-Stage Renal Disease-related services included in the monthly capitation payment
- 96116: Neurobehavioral status examination

- 96150 – 96154: Individual and group health and behavior assessment and intervention
- 97802 – 97804 and G0270: Individual and group medical nutrition therapy
- 99201 – 99215: Office or other outpatient visits
- 99231 – 99233: Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days
- 99307 – 99310: Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days
- 99406 and 99407 and G0436 and G0437: Smoking cessation services
- G0108 and G0109: Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training
- G0396 and G0397: Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services
- G0406 – G0408: Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs
- G0420 and G0421: Individual and group kidney disease education services
- G0425 – G0427: Telehealth consultations, emergency department or initial inpatient
- G0442: Annual alcohol misuse screening, 15 minutes
- G0443: Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
- G0444: Annual depression screening, 15 minutes
- G0445: High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes
- G0446: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes
- G0447: Face-to-face behavioral counseling for obesity, 15 minutes
- G0459: Inpatient pharmacologic management

Eligible Providers

Only the following health professionals may claim reimbursement for remote telehealth services:¹

- Physician;
- Nurse practitioner;
- Physician assistant;
- Nurse midwife;
- Clinical nurse specialist;
- Clinical psychologist,*
- Clinical social worker,* and
- 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.

¹ Ibid, Part 270.4 – Payment – Physician/Practitioner at a Distant Site

Eligible Facilities

Only the following facilities are eligible to be an originating site under the rules of the program:²

- The office of a physician or practitioner
- A hospital, including a critical access hospital
- A rural health clinic
- A federally qualified health center
- A skilled nursing facility
- A hospital-based dialysis center
- A community mental 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 non-metropolitan facility 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." For billing policies and recent changes regarding telehealth services see a recent CMS document (Pub 100-04 Medicare Claims, Transmittal 106) located at <http://www.cms.hhs.gov/Transmittals/Downloads/R1026CP.pdf>. For the most recent payment policies regarding the telehealth originating site fee see the CMS document "MLN Matters Number: MM5443" located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5443.pdf>.

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.

² Ibid, Part 270.01 – Eligibility Criteria

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.³

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.”⁴

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 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

³ CMS Carriers Manual Part 3 Chapter IV Claims Review and Adjudication Procedures
http://www.cms.hhs.gov/manuals/14_car/3b4120.asp

⁴ Medicare benefit policy manual, Part 15 – Covered Medical and Other Health Services, 30-Physician Services pp 10-11. (http://www.cms.hhs.gov/manuals/102_policy/bp102c15.pdf)

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. This provision does not waive the current statutory requirement for a physician certification of a home health plan of care under current §§1814(a)(2)(C) or 1835(a)(2)(A) of the Act.⁵

Within its home health agency manual, CMS states that “An HHA may adopt telehealth technologies that it believes promote efficiencies or improve quality of care. Telehomecare encounters do not meet the definition of a visit set forth in regulations at 42 CFR 409.48(c) and the telehealth services may not be counted as Medicare covered home health visits or used as qualifying services for home health eligibility. An HHA may not substitute telehealth services for Medicare-covered services ordered by a physician. However, if an HHA has telehealth services available to its clients, a doctor may take their availability into account when he or she prepares a plan of treatment (i.e., may write requirements for telehealth services into the POT). Medicare eligibility and payment would be determined based on the patient’s characteristics and the need for and receipt of the Medicare covered services ordered by the physician. If a physician intends that telehealth services be furnished while a patient is under a home health plan of care, the services should be recorded in the plan of care along with the Medicare covered home health services to be furnished.”⁶

National and Local Coverage Decisions

Certain national coverage determinations by CMS has further expanded and explained coverage. For example, Part 20.8.1.1 of the National Coverage Determinations manual covers transtelephonic monitoring of cardiac pacemakers and Part 20.15 covers electrocardiographic services⁷ (see below).

⁵ Medicare Benefit Policy Manual Chapter 7 Home Health Services, Part 110

⁶ Publication 11 - Home Health Agency Manual - Chapter II - Coverage of Services, Part 201.13

<http://www.cms.hhs.gov/manuals/cmstoc.asp>

⁷ *50-39 TELEPHONE TRANSMISSION OF ELECTROENCEPHALOGRAMS

Telephone transmission of electroencephalograms (EEGs) is covered as a physician’s service or as incident to a physician’s service when reasonable and necessary for the individual patient, under appropriate circumstances. The service is safe, and may save time and cost in sending EEGs from remote areas without special competence in neurology, neurosurgery, and electroencephalography, by avoiding the need to transport patients to large medical centers for standard EEG testing.

Telephone transmission of EEGs has been most helpful in the following clinical situations:

- Altered consciousness, such as stuporous, semicomatose, or comatose states;
- Atypical seizure variants in patients experiencing bizarre, distressing symptoms as seen with "spike and wave stupor" or other forms of seizure disorders;
- Diagnosis of a suspected intracranial tumor;
- Head injury, where a subdural hematoma may be identified;
- Headaches during the acute phase where, for instance, in migraine syndrome, abnormal responses may be seen.

Telephonically transmitted EEGs should not be used for determining electrical inactivity (i.e., brain death), because of unavoidable signal interference.

In addition, local intermediaries are allowed to make their own local determinations regarding, which may further expand coverage. For example, the Arkansas Blue Cross Blue Shield - Rhode Island intermediary has a ruling titled: Transtelephonic Spirometry where patient initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation are covered.

Cardiac monitoring

Medicare also covers two types of cardiac monitoring:

- **Transtelephonic monitoring of cardiac pacemakers (CPT code 93293) is for identifying early signs of possible pacemaker failure, thus reducing the number of sudden pacemaker failures requiring emergency replacement.**
- **Ambulatory electrocardiography (AECG) refers to services rendered in an outpatient setting over a specified period of time, generally while a patient is engaged in daily activities. AECG devices are intended to provide the physician with documented episodes of arrhythmia, which may not be detected using a standard EKG. AECG is most typically used to evaluate symptoms that may correlate with intermittent cardiac arrhythmias and/or myocardial ischemia. The AECG are both patient/event-activated and continuous recorders and use CPT codes 93271 and 93012. These services are performed by independent diagnostic testing facilities (IDTFs).**