

This guide is intended to explain what telemedicine services are covered by public and private insurance programs and what is required of health care providers and organizations to obtain reimbursement for services delivered by telemedicine.

We hope to provide a streamlined review of coverage policies and regulations for Medicare (page 2), Medicaid (page 6), and private insurance (page 10).

The Northeast Telehealth Resource Center (NETRC) would like to thank Michael Edwards, PhD, consultant for NETRC, and Kim Mohan for their contributions to our series of reimbursement guides. For additional questions, clarifications, or to share your experiences, please contact the NETRC team by phone (800-379-2021) or by email (netrc@mcdph.org).

Overview of Act 107 provisions

The enactment into law (Act 107) of the bill H.37 passed by the legislature in 2011 supports parity for reimbursement between delivery of care in-person and delivery by live, interactive telemedicine. This door to coverage of telemedicine services by both private and public (Medicaid) insurance programs makes Vermont a very favorable environment for application of telehealth solutions to enhance cost effective care delivery and to address disparities in health and health care access.

The core provision of Act 107 begins with the first part of Section 1:

All health insurance plans in this state shall provide coverage for telemedicine services delivered to a patient in a health care facility to the same extent that the services would be covered if they were provided through in-person consultation.

At present, there are no complex regulations in place beyond using a GT code modifier in the billing code for covered services. Act 107 also makes it clear in Section 4 that it applies to all licensed health care providers, while specifying that the same standards of care for medically necessary services should be applied as for services delivered through in-person care:

Subject to the limitations of the license under which the individual is practicing, a health care provider licensed in this state may prescribe, dispense, or administer drugs or medical supplies, or otherwise provide treatment recommendations to a patient after having performed an appropriate examination of the patient either in person or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically. Treatment recommendations made via electronic means, including issuing a prescription via electronic means, shall be held to the same standards of appropriate practice as those in traditional provider–patient settings.

In practice the covered services are restricted to patients at “health care facilities”. The Commissioner of Financial Regulation was delegated in Section 6 of the law to form a workgroup to review the potentials for service delivery “outside a health care facility” (i.e. home or social service site for outreach provision of care). We are unaware of an official report from this review or of expansions in covered service delivery sites.

The restriction of approved service delivery mode to interactive telemedicine resembles that of the Medicare program. However, while Medicare doesn’t cover non-interactive telemedicine delivery by “store and forward” means (services completed by review of medical information and special images collected at a different time), Act 107 leaves coverage optional for private and public program policies. The specific services singled out included tele-ophthalmology and teledermatology services.

Private and public insurance programs are also given the option to gather information relevant to future policy changes, i.e. reasons for service delivery by telemedicine. The law gives power to the Commissioner of Financial Regulation and the Commissioner of Vermont Health Access to establish rules applying to telehealth services. If a particular approach for delivery of care by telemedicine turns out to be obviously not cost-effective, one can imagine restrictions in coverage down the line.

MEDICARE

Overview

The Centers for Medicare and Medicaid Services (CMS) has been reimbursing for services delivered by telemedicine to Medicare patients since the Balanced Budget Act of 1997. In 2001, under the Medicare, Medicaid and SCHIP Benefits Improvement Protection Act of 2000, CMS broadened the range of services covered and established procedures to institute changes each year in the types of treatment covered, eligible providers, or patient presentation sites allowed.

Over the years, CMS continues to require that the services be delivered through “an interactive telecommunications system”, defined as “multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient and the practitioner at the distant site.”

Another key restriction specified by law is that the patient site (“originating” site) be in a rural Health Professional Shortage Area (HPSA). In practice, a site is currently deemed eligible for telehealth coverage if it is in a county without a Metropolitan Statistical Area or, if not, in a non-urban census tract that also lies within a Health Professional Service Area. The Health Resources and Services Administration in 2013 developed a Web site which provides an eligibility assessment for any address entered by an interested party: <http://datawarehouse.hrsa.gov/telehealthAdvisor/telehealthEligibility.aspx>

By these rules patient access sites in all counties of Vermont except for Chittenden and some census tracts in Grand Isle and Franklin Counties are eligible.

Limitations and exclusions

The telemedicine benefit is limited to specific originating, or patient, sites, specific services, and certain categories of providers (see below).

CMS excludes treatment carried out solely by telephone, facsimile, or e-mail. This includes “store-and-forward” telemedicine services that commonly involve electronic transmission of diagnostic medical information from the patient site for review at a later time by a specialist at a distant site.

Eligible originating site facility where patient is located:

- Office of a physician or practitioner
- Rural Health Clinic
- Federal Qualified Health Center
- Hospital
- Critical Access Hospital
- Skilled Nursing Facility
- Hospital-based Renal Dialysis Centers (including satellites)
- Community Mental Health Centers

Home telehealth

One should notice that a patient’s home is not an eligible originating site. In the case of home telehealth services, agencies may adopt them to enhance efficiencies of care to Medicare patients as long as the primary care provider ordering the services takes them into account in the plan of care. However, no special reimbursement applies to the use of such technologies, and agencies are not allowed to substitute home telehealth visits or monitoring for in-person visits specified in the plan of care. Unlike Medicare Part B services, home health care under Medicare is reimbursed not per visit but since 2000 for levels of service under the “Prospective Payment System”. (Source: CMS Home Health Agency Manual, Chapter II, Part 201.13-- <http://www.cms.hhs.gov/manuals>).

Qualified services

Each year new procedures are added to the list of qualified services. This is the 2015 set of telemedicine procedures currently subject to reimbursement. For information on reimbursement coverage limitations for these services, whether by in-person or telemedicine delivery, please consult the *Medicare National Coverage Determinations Manual* (see link in Resources section on page 6).

Qualified Procedures	CPT/ HCPCS Codes
Office or other outpatient visits	99201 – 99215
Annual wellness visit (<i>started 2015</i>)	G0438, G0439
Telehealth consultations, emergency department or initial inpatient	G0425 – G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406 – G0408
Subsequent hospital care services (1 visit every 3 days)	99231 – 99233

Continued

Qualified Procedures Continued	CPT/ HCPCS Codes
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307 – 99310
Psychiatric diagnostic interview examination	90791, 90792
Individual psychotherapy	90832 - 90834, 90836 - 90838
Neurobehavioral status exam	96116
Psychoanalysis (<i>started 2015</i>)	90845
Family psychotherapy, without or with patient (<i>started 2015</i>)	90846, 90847
Telehealth Pharmacologic management	G0459
Individual and group diabetes self-management training services, with a min. 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training	G0108 – G0109
Individual and group medical nutrition therapy	G0270, 97802- 97804
Individual and group kidney disease education (KDE)	G0420, G0421
End-stage renal disease (ESRD)-related services included in the monthly capitation payment	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
Prolonged evaluation and management services requiring direct patient contact (<i>started 2015</i>)	99354, 99355
Individual and group health and behavior assessment and intervention (HBAI)	96150 - 96154
Smoking cessation services	G0436, G0437, 99406, 99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	G0396, G0397
Annual alcohol misuse screening (15 min.)	G0442
Brief face-to-face behavioral counseling for alcohol misuse (15 min.)	G0443
Annual depression screening (15 min.)	G0444
High-intensity behavioral counseling for individuals to prevent sexually transmitted infections (30 min.)	G0445
Annual intensive behavioral therapy for cardiovascular disease, individual (15 min.)	G0446
Behavioral counseling for obesity (15 min.)	G0447
Transitional care management services, moderate and high complexity	99495, 99496

Eligible distant site providers include (subject to state law):

- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Clinical nurse specialist
- Clinical psychologist
- Clinical social worker
- Registered dietitian or nutrition professional

It should be noted that there is no requirement for a professional presenter to be present at the patient site during the session.

Billing procedures

The amount of reimbursement that providers may bill for under Medicare Part B is equivalent to what they charge for face-to-face services. All billing for telemedicine services should be carried out as per the normal billing process of your institution. Consulting physicians will use their normal billing process, but a secondary diagnosis code of “-GT” must be appended to the usual procedure code to identify delivery by telemedicine (“GQ” for store-and-forward telemedicine at approved programs in Hawaii and Alaska). The usual Medicare deductible and coinsurance policies apply to the telehealth services reported by distant site practitioners.

Facility fee for the originating site

CMS recognizes that the facility which hosts patient access to a remote provider deserves some compensation for this service, which is the origin of the telehealth site facility fee. The organization at the patient site can receive this fee by submitting a claim with HCPCS code Q3014. The originating site facility fee payment methodology for each type of facility is clarified in the Medicare Claims Processing Manual, Chapter 12, Section 190.6 (<http://www.cms.hhs.gov/manuals>).

The usual Medicare deductible and coinsurance policies apply to HCPCS code Q3014. By submitting HCPCS code Q3014, the originating site authenticates that it is located in either a rural HPSA or non-MSA county. 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. The reimbursement made is 80 percent of the lesser of the actual charge or \$24.63 in 2015 (amount set each year in the *Medicare Physician Fee Schedule Final Rule*).

Billing for other services delivered remotely not requiring telehealth coding

In the 2015 Medicare Physician Fee Schedule publication, CMS clarified some important issues with respect to reimbursement for certain services carried out in association with care delivered by telemedicine:

As previously described, certain professional services that are commonly furnished remotely using telecommunications technology, but that do not require the patient to be present in-person with the practitioner when they are furnished, are covered and paid in

the same way as services delivered without the use of telecommunications technology when the practitioner is in-person at the medical facility furnishing care to the patient. Such services typically involve circumstances where a practitioner is able to visualize some aspect of the patient's condition without the patient being present and without the interposition of a third person's judgment. Visualization by the practitioner can be possible by means of x-rays, electrocardiogram or electroencephalogram tracings, tissue samples, etc. For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram tracing that has been transmitted via telephone (that is, electronically, rather than by means of a verbal description) is a covered physician's service. These remote services are not Medicare telehealth services as defined under section 1834(m) of the Act. Rather, these remote services that utilize telecommunications technology are considered physicians' services in the same way as services that are furnished in-person without the use of telecommunications technology; they are paid under the same conditions as in-person physicians' services (with no requirements regarding permissible originating sites), and should be reported in the same way (that is, without the -GT or -GQ modifier appended).

Also included in the 2015 Fee Schedule is a new CPT service code for chronic care patient management for patients with two or more chronic disease conditions (99490). This is technically not a telehealth code as it does not require the patient to be present and thus can be used regardless of patient location (i.e. not restricted with respect to rural sites). A minimum of 20 minutes a month of service must be recorded and duplication with respect to related service codes is not permitted (e.g. Transitional Care Management or Prolonged Evaluation/Management Services).

Medicare Resources for further review and updates on Medicare:

For additional details and annual updates about Medicare coverage of telehealth services, please consult the following:

Medicare manuals -- <http://www.cms.hhs.gov/manuals>

- *Medicare Benefit Policy Manual*, CMS Pub. 100-2, Chapter 15, Section 270
- *Medicare National Coverage Determinations Manual*, Pub. 100-03, Chapt. 1, Section 210
- *Medicare Claims Processing Manual*, Pub. 100-4, Chapter 12, Section 190

Medicare Physician Fee Schedule Final Rule, Federal Register

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/FederalRegulations.html>

California Telehealth Resource Center Telemedicine Reimbursement Guide, 2014

<http://www.caltrc.org/knowledge-center/reimbursement/>

MEDICAID AND VERMONT HEALTH ACCESS PROGRAMS

Overview

Vermont's Medicaid and other public insurance programs as of October 2012 were mandated by Act 107 ("An act relating to telemedicine") to reimburse for medically necessary health care services delivered by telemedicine if already covered for in-person delivery. Like Medicare policy, it restricts coverage to services delivered only through live, interactive sessions using two-way video and audio technology (videoconferencing).

Reimbursement rates are at par with in-person services, and the co-pay may not exceed that for in-person services. Currently, the originating site (patient site) must be a health care facility. Act 107 calls for a review and recommendation on coverage of services at non-medical facilities by a work group to be delegated by the Commissioner of Financial Regulation (report due Jan. 15, 2013).

The Department of Vermont Health Access has established an interim guideline which represents a simple and streamlined approach for providers to access reimbursement for services under Act 107. This procedural guidance is inserted into a new chapter of the Green Mountain Care Consolidated Provider Manual(Section 11.3.51, "Coverage for Services Delivered via Telemedicine", p. 104; <http://www.vtmedicaid.com/Downloads/manuals.html>):

Effective with October 1, 2012 Dates of Services, the Department of Vermont Health Access (DVHA) is implementing telemedicine pursuant to Act 107 from the 2011-2012 Legislative Session: 1) Distance site providers are required to follow correct coding in the application of the GT modifier - CMS and/or Encoder Pro telemedicine codes excluding non-covered services, 2) Originating site providers (patient site) are required to document the reason the service is being provided by telemedicine rather than in person and may be reimbursed a facility fee (Q3014). The DVHA will monitor the rollout including the impact on service utilization and costs, and perform retrospective reviews.

Telemedicine is defined in Act 107 as "...the delivery of health care services...through the use of live interactive audio and video over a secure connection that complies with the requirements the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.

Details about how "to document the reason the service is being provided by telemedicine rather than in person" is not specified. Does this process have to be carried out for each service billed or can it apply as an "approval" process for services established between a provider and a particular health care facility? The Policy Director encourages queries to contacts listed for the Vermont Medicaid Portal, including Health Plan Provider Services (800-925-1706), Claims Questions (800-918-7545), and Prior Authorization (800-918-7549).

Limitations and exclusions

As with Medicare, services delivered by telephone, fax, or e-mail are not reimbursable. Similarly, telemedicine applications such as teledermatology or tele-ophthalmology that are based exclusively on review of medical images or other diagnostic data transmitted electronically are not covered.

Section 1f specifies that: "Nothing in this section shall be construed to require a health insurance plan to reimburse the distant site health care provider if the distant site health care provider has insufficient information to render an opinion." This provision supplies an option for the Department of to reject a claim based on inadequacies in the capabilities of the telemedicine system to allow the provider to make a diagnosis or treatment decision.

The provision in the policy that the communication system used in the delivery of telemedicine be secure in accordance with HIPAA provisions is consistent with Act 107 specifications in Section 4 that: "Treatment recommendations made via electronic means, including issuing a prescription via electronic means, shall be held to the same standards of appropriate practice as those in traditional provider–patient settings." Thus, the services delivered by telemedicine must meet the quality assurance standards for all health care services as overseen by the Vermont medical licensing division. Potential telemedicine providers should also consider compliance of the service delivery standards of the Joint Commission and other credentialing organizations and their organizational clinical practice liability policies before initiating services.

Eligible originating sites, or facility where patient is located

As of October 2012, Act 107 applies to services delivered by telemedicine to originating (patient) sites at health care facilities. As defined in Title 18 of the Vermont Statutes (18 V.S.A. 9402; <http://www.leg.state.vt.us/statutesMain.cfm>):

"Health care facility" means all institutions, whether public or private, proprietary or nonprofit, which offer diagnosis, treatment, inpatient, or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any facility operated by religious groups relying solely on spiritual means through prayer or healing, but includes all institutions included in subdivision 9432(10) of this title, except health maintenance organizations.

Provision 9432(10) specifies that health care facilities:

shall include but is not limited to:

- (A) hospitals, including general hospitals, mental hospitals, chronic disease facilities, birthing centers, maternity hospitals and psychiatric facilities including any hospital conducted, maintained or operated by the state of Vermont, or its subdivisions, or a duly authorized agency thereof;*
- (B) nursing homes, health maintenance organizations, home health agencies, outpatient diagnostic or therapy programs, kidney disease treatment centers, mental health agencies or centers, diagnostic imaging facilities, independent diagnostic laboratories, cardiac catheterization laboratories, radiation therapy facilities or any inpatient or ambulatory surgical, diagnostic or treatment center.*

Thus, sites such as homes, schools, and social service agency offices are excluded for patient access sites to receive reimbursable care. The date of January 15, 2013 is set as a deadline for completion of a workgroup report on the advisability of expanding the range of approved originating sites.

Readers of this guide should note that telehealth services delivered by home health agencies to patients at home are not reimbursable by the Department of under the provisions and policies of Act 107. However, as is the case for CMS implementation of home health fee-for-performance provisions, there may be managed care programs for special populations for which telehealth is not excluded as a means to deliver care according to the patient's health care plan. This consideration is not applicable to fee-for-service programs.

Qualified services

This is open to any service covered by the Department of Vermont Health Access plans.

Eligible providers

This is open to provider types whose regular face-to-face services are reimbursable by the Department of Vermont Health Access. This includes services delivered at hospitals accessible to Vermont residents in neighboring states. These out-of-state hospitals approved for delivery of services to DVHA beneficiaries include:

Green Mountain Care In-Network Hospitals

- Alice Peck Day Hospital, Lebanon, NH
- Cottage Hospital, Woodsville, NH
- Dartmouth Hitchcock Medical Center, Lebanon, NH
- Glens Falls Hospital, Glens Falls, NY
- Littleton Hospital, Littleton, NH
- North Adams Hospital, No. Adams, MA
- Upper Connecticut Valley Hospital, Colebrook, NH
- Valley Regional Hospital, Claremont, NH
- Weeks Memorial Hospital, Lancaster, NH

Green Mountain Care Extended-Network Hospitals

- Albany Medical Center, Albany NY
- Cheshire Medical Center, Keene, NH

Billing procedures

Services are to be billed in accordance with applicable sections of Vermont's Green Mountain Care Consolidated Provider Manual. Providers must submit claims in accordance with billing instructions. The same procedure codes and rates apply as for services delivered in person. The GT (Interactive Telecommunication) modifier must be used along with the appropriate HCPC code when billing for services provided via telemedicine.

The providers seeking reimbursement for telemedicine services are required to document why delivery by telemedicine was adopted instead of by in-person care. The details for how and how often submission of this information should be made has not yet been specified. No contingency in payments based on such submissions has been suggested.

Resources for further review and updates:

For additional details and annual updates about DVHA's coverage of telemedicine services, please consult the Vermont Medicaid Portal: <http://www.vtmedicaid.com/index.html>

PRIVATE INSURANCE

Vermont Act 107 specifies that its provisions apply to all new policies and annual policy renewals after October 1, 2012. In other words, patients are not eligible for the telemedicine benefit until policies in effect before that time are renewed.

So far, we have been able to obtain information on telemedicine policies from two private health insurance providers, that of MVP and BlueCross and BlueShield of Vermont. As providers move forward on implementing provisions of Act 107, there are bound to be differences in interpretation in how the law is applied for individual health plans and policies. If you feel a billing claim has been improperly denied, the Vermont Department of Financial Regulation, which oversees health insurance practice, advises consumers to first complete the health plan's internal complaint process, as described in the denial of claims letter. The consumer Webpage (<http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-services>) further advises:

If you are still unhappy with your plan's decision, you may have the right to get an independent review of that decision by appealing your denial. Contact Consumer Services at 1-800-964-1784 to see if you qualify for external appeal.

Limitations and exclusions

As with Medicare, Medicaid, and the Vermont Health Access programs, eligible telemedicine services are those that employ live, interactive audio-visual sessions with the provider and do not include the use of audio-only telephone, facsimile machine or e-mail. The health insurance provider has the option to reimburse for teledermatology or tele-ophthalmology services delivered by store-and-forward methods. From shared responses to queries from a Vermont health care organization, we have learned that BlueCross BlueShield of Vermont chooses not to use that option. However, similar queries made to MVP revealed that they plan to reimburse for these store-and-forward services.

Eligible originating site (facility where patient is located)

Parity of telehealth services with the service provisions for in-person care is implied in the law. The law specifies that interactive, real-time telemedicine delivery of eligible services by eligible providers should be reimbursed as long as the originating site is a health care facility. This includes hospitals, nursing homes, ambulatory care centers for medical diagnosis and treatment, and mental health agencies or centers. In the case of BlueCross and BlueShield of Vermont, a shared communication from them with health care providers suggests that for them only in-patient facilities will be considered eligible patient presentation sites for telemedicine services. This includes hospitals, skilled nursing facilities, and renal dialysis centers in their contracted network. As of October 2012, they were advising these provider organizations that common primary care sites such as doctors' offices or community health centers would not be eligible as patient presentation sites.

Qualified services

As with the public insurance programs of the Department of Vermont Health Access, any medically necessary in-person services covered by the insurance provider should also be covered when delivered by telemedicine. However, for BlueCross and BlueShield, the above current restriction for originating sites to inpatient hospitals, nursing homes, and

dialysis centers results in an effective restriction in the range of eligible services to those covered for those sites in the particular patient's policy.

As noted above, MVP has indicated that they plan to reimburse for teledermatology and tele-ophthalmology delivered by store-and-forward technology. They require a written justification of the reason for use of this approach before completing the service.

CIGNA Healthcare of Vermont, even before the new telemedicine law was enacted, stood out for being open to covering services delivered by diverse electronic means, including telephone and e-mail, when deemed medically necessary for geographically remote patients..

Eligible providers

Parity is effectively mandated for the range of providers eligible to deliver care by telemedicine as approved for in-person care. As with in-person care, an insurer may limit telemedicine service coverage to providers and health care organizations within their contracted network. Typically, utilization of an "out of network" provider requires prior authorization, and a larger co-pay is usually required than when a network provider is used.

In the case of BlueCross and BlueShield, eligible providers correspond to physicians, naturopaths, psychiatrists, or psychologists that are contracted to serve in the plan's provider network.

Billing procedures

All billing for telemedicine should be carried out as per the normal billing process of your institution. Consulting physicians will use their normal billing process, but, as with Medicare and Medicaid clients, a GT modifier must be added to the CPT billing codes submitted for interactive sessions and a GQ modifier for services delivered by store-and-forward.

CIGNA has an atypical range of service coverage. It is worth noting that it allows reimbursement under CPT codes for telemedicine assessment and monitoring of critical care patients, telephonic monitoring and transmission of EKGs and pacemaker evaluations, and online assessment and management services carried out using the Internet.

The Act 107 statute makes no requirements for coverage of an originating site facility fee. However, MVP's communications with providers indicate that originating site may submit a claim for such a payment to help defray the costs of hosting and presenting a patient to the distant provider. The code to use is Q3014.

Health care provided by telemedicine may be subject to deductible, co-payment, or co-insurance requirements as long as they do not exceed the deductible, co-payment, or co-insurance applicable to an in-person consultation.

Resources for further review and updates:

Please check with Web sites of private insurance providers for updated policies on coverage of services delivered by telemedicine and procedural requirements for submission of claims.

CONCLUSION

The rules for Medicare reimbursement are clear and are becoming progressively more inclusive of medical services each year, but service delivery must include live interactive video sessions. The other key restrictions are that eligible sites for patient access must be at specific health care facilities and that they must be located in rural, underserved areas designated as Health Professional Shortage Areas.

Vermont's reimbursement policy for its Medicaid program and the Vermont Health Access Program is more flexible in the geography of eligible sites for patient access and in the range of services covered. The justification for the use of telemedicine required of providers is not currently being judged as a basis for accepting or denying a claim.

Private insurance provider coverage of services delivered by telemedicine is guaranteed under the new law, subject to the same restrictions as apply to in-person services covered under the health care policy. One insurance provider, BlueCross and BlueShield of Vermont, appears to be planning reimbursement for telemedicine services delivered to patients located in hospitals, nursing homes, or dialysis centers in their network.

We recommend that any community health center seeking to serve as the originating site review the California Telehealth Resource Center's Telemedicine Reimbursement Guide (<http://www.caltrc.org/knowledge-center/reimbursement/>). Whatever the insurance provider, there are a number of scenarios that apply to delivery of telemedicine services. Normally, the site where the telemedicine provider is located corresponds to the billing location. However, under certain contractual relations between a specialty care provider and a primary care facility (such as a Federally Qualified Health Center), the latter may act as the billing entity. Establishing which billing scenario works best and is acceptable to the insurance provider needs to be worked out in parallel with that of the telemedicine service procedures.

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