

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 1), Medicaid (page 5), and private insurance (page 6).

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).

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>

Limitations and exclusions

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

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 5).

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
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307 – 99310
Psychiatric diagnostic interview examination	90791, 90792

Continued

Qualified Procedures Continued	CPT/ HCPCS Codes
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

Continued

- 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

Connecticut Medicaid does not currently opt to cover telemedicine services under its various HUSKY Health Plans. The only exception we have discovered is in the case of telephone or videoconferencing based case management services for children under 18 years of age (cited in the *Connecticut State Medicaid Provider Manual*, Behavioral Health, Section 17b-262-918, p. 6).

Although there is no legislative mandate for the state Medicaid program to reimburse for health services delivered by telemedicine, a law in effect as of January 2013 (Public Act #12-209) authorizes the Department of Social Services to implement a demonstration Medicaid reimbursement program for telemedicine services delivered to Federally Qualified Health Centers (<http://cga.ct.gov/2012/FC/2012HB-05483-R000559-FC.htm>). The goal of the program is to enhance services to individuals who have difficulty gaining access to primary care. To date, we find no indication such a pilot program was carried out.

For programs that aim to use telemedicine or telehealth services for special populations of underserved and disabled patients, it is worth discussing this interest with the State Medicaid administration. It is conceivable that a pilot status for such a program would be conferred if a good argument can be made that the approach addresses geographic and population disparities in health care access and/or to enhance the cost-effectiveness of health care delivery. The contact information for such an enquiry is as follows:

*Medical Care Administration Director
Department of Social Services
25 Sigourney Street, Hartford, CT 06106
860-424-5112*

PRIVATE INSURANCE

Bills mandating private insurance coverage of telemedicine services have been considered by the Connecticut General Assembly in recent years, but none have passed into law. Despite having no legal mandate to do so, a number of insurance programs and employee health care plans do reimburse for services delivered by telemedicine. Providers and patients interested in coverage of telemedicine or telehealth services are encouraged to query the relevant insurance plan providers what their reimbursement policy is.

For example, as a national policy United Healthcare (Golden Rule Insurance in Connecticut) has chosen to reimburse for medical care provided through live, interactive videoconferencing using CMS Medicare provisions for eligible originating sites and eligible services. They even cover telemedicine delivery of medical genetics and genetic counseling services not currently subject to Medicare reimbursement. The Connecticut General Life Insurance Company (aka Cigna) provides an even broader range of coverage options, extending to reimbursement for services delivered by telephone and e-mail when justified by the medical needs of geographically remote patients. In contrast, for Anthem Blue Cross and Blue Shield of Connecticut, we are aware of reimbursement only for remote retinal screening in diabetics. Aetna cites a similar policy of coverage for this service. Their written policies also cite coverage of remote monitoring of cardiac events for certain diagnoses and telephonic transmission of pacemaker assessment data in ambulatory patients; however, they exclude reimbursement for remote telemonitoring of chronic heart failure patients.

CONCLUSION

The rules for Medicare reimbursement of telemedicine services are clear and are becoming progressively more inclusive of medical services each year. However, 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 either in underserved rural areas designated as Health Professional Shortage Areas or in a county without a sizeable city designated as a Metropolitan Statistical Area.

Given the recent legislation authorizing a pilot study of Medicaid coverage of services to community health centers, it is clear that policy makers are attracted to prospects of telemedicine to enhance service access to underserved populations. Clinical providers serving special populations with access barriers might consider requesting to be part of

such a pilot program, which has yet to be enacted. Meanwhile, more and more private insurance providers are adopting coverage of telemedicine and telehealth services on their own. Bills mandating coverage from all insurance providers get closer to being passed as the years go by.

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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