

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 7).

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>

Under these operational rules, patients at approved facilities are eligible throughout New Hampshire except for most of Hillsborough and Rockingham Counties

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 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

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/>

New Hampshire Medicaid

Overview

There is no legislative mandate for the state Medicaid program to reimburse for health services delivered by telemedicine. However, the New Hampshire Department of Health and Human Services has shown much interest in embracing telemedicine and the broader sphere of telehealth to address solutions for enhancing health care access and cost-

effective delivery of services, and growth. There are currently two scenarios where telemedicine services are being reimbursed.

Currently, Medicaid reimbursement is provided in two specific instances, telepsychiatry delivered to patients of community mental health centers and remote monitoring (including subsidization of the monitoring equipment) for participants in the New Hampshire Community Passport Program: <http://www.dhhs.nh.gov/dcbcs/beas/nhcp/>

All program inquiries should be directed to the NHCPP Coordinator at: (603) 271-9217 or (800) 852-3345 ext. 9217, or by mail to the NH Community Passport Program, 129 Pleasant Street, Concord, NH 03301.

These examples suggest that the New Hampshire Office of Medicaid Business and Policy may be open to requests to deliver certain categories of health care by telemedicine or telehealth. Their office encourages organizations interested in file a request for reimbursement to send letters to:

Kathleen Dunn, Medicaid Director
129 Pleasant Street
Concord, NH 03301

When drafting a request for consideration, a good argument must be made that delivery of care by these means addresses disparities in health care access for underserved populations and is likely to reduce overall costs of care by preventing hospitalization or residential long term care.

Limitations and exclusions

For telepsychiatry services, the client may be any Medicaid covered patient who presents at one of the Community Mental Health Centers.

The home telehealth benefit is applicable only to clients enrolled in the Community Passport Program, eligibility for which requires the patient to be disabled in at least one of the four criteria of the Medicaid waiver programs and either residence in a long-term care facility or approval for placement.

Eligible originating sites (facility where patient is located)

A Community Mental Health Center is the only eligible site for client access to telepsychiatry services. The remote telehealth monitoring service is used in the home setting.

Qualified services

As of this time, telepsychiatry provided to patients of a Community Mental Health Center and remote telehealth monitoring to participants in the Community Passport Program are the only services qualified for Medicaid reimbursement.

Eligible providers

In the case of Telepsychiatry, providers are appointed by the Community Mental Health Centers. The NH Community Passport Program is responsible to appoint their providers.

Billing procedures

The Bureau of Behavioral Health has established procedures for clinical and informed consent protocols as a prerequisite for telepsychiatry services to be reimbursable by Medicaid. Billing should use the usual code for in-person services followed by the GT modifier.

Resources for further review and updates:

- Look for notices about benefit changes at the Web page of Office of Medicaid & Business Policy :
<http://www.dhhs.nh.gov/ombp/medicaid/index.htm>.

PRIVATE INSURANCE

Overview

Under the New Hampshire Telemedicine Act (415-J), enacted into law in October 2009, all private health insurance policies for individuals or groups and health maintenance organization plans “must provide coverage for health care services that are provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a health care provider.” The statute provides further clarification on its scope:

- I. *It is the intent of the general court to recognize the application of telemedicine for covered services provided within the scope of practice of a physician or other health care provider as a method of delivery of medical care by which an individual shall receive medical services from a health care provider without in-person contact with the provider.*
- II. *An insurer offering a health plan in this state may not deny coverage on the sole basis that the coverage is provided through telemedicine if the health care service would be covered if it were provided through in-person consultation between the covered person and a health care provider.*
- III. *Nothing in this section shall be construed to prohibit an insurer from providing coverage for only those services that are medically necessary and subject to the terms and conditions of the covered person’s policy*

Limitations and exclusions

According to the language of the NH Telemedicine Act, telemedicine “means the use of audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include the use of audio-only telephone or facsimile.” This definition from the statute does not exclude telemedicine delivery by store-and-forward methods. It remains to be seen whether such an exclusion is enacted by policies

of the NH Insurance Department.

CIGNA Healthcare of New Hampshire, even before the Telemedicine Act was enacted, stands 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 originating sites (facility where patient is located)

The state law does not define or restrict the originating site. It remains to be seen what sites will be specified by state policy as eligible originating sites: a provisional document previously accessible at the Insurance Department Website restricted eligible sites to the subset specified by CMS for Medicare coverage of services delivered by telehealth. Some telemedicine policies of private insurance providers make no mention of a site restriction. In the case of United Healthcare, their policy dated April 2011 lists as eligible the full set of originating sites listed for Medicare.

Qualified services

The NH Telemedicine Act does not specify any limitations in the types of telemedicine services covered, only that they correspond to services already covered for in-person care.

As with in-person care, an insurer may limit telemedicine service coverage to providers within their approved network. Typically, utilization of an “out of network” provider requires prior authorization, and a larger co-pay is usually required than when a contracted network provider is used.

Eligible distant site providers

There are no restrictions under the Telemedicine Act regarding which distant clinical providers are eligible for reimbursement for telemedicine services. However, as with in-person care, an insurer may limit telemedicine service coverage to providers within their approved network. Typically, utilization of an “out of network” provider requires prior authorization, and a larger co-pay is usually required than when a contracted network provider is used.

Billing procedures

All billing for telemedicine should be carried out according to the normal billing process for in-person services. As with Medicare and Medicaid clients, most insurance providers specify that a “GT” modifier code must be appended to the usual CPT and HSPCS codes.

CIGNA allows reimbursement under CPT codes beyond the set approved by Medicare for telehealth services. These include 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 provisional state policy previously posted specified that a facility fee for the originating site hosting the patient presentation may be claimed using the code Q3014 (on a UB 92 form for hospitals and a CMS 1500 form for other facilities). A table in that policy

document indicated that both CIGNA and Anthem Blue Cross/Blue Shield have opted to provide reimbursement for this.

Health care provided by telemedicine may be subject to a deductible, co-payment, or co-insurance requirement as long as they do not exceed the deductible, co-payment, or co-insurance applicable to an in-person consultation. HealthFirst Benefit Summaries from four private health insurance companies approved for this program indicate equivalent shared costs for in-person and telemedicine services.

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 in rural, underserved areas designated as Health Professional Shortage Areas.

New Hampshire has very limited reimbursement for telemedicine or telehealth in its Medicaid program. Telepsychiatry delivered for patients at community health centers and telehealth remote monitoring in home health care for patients in a CMS demonstration project are the only covered services we are aware of. However, a health care organization which seeks to enhance cost-effective health care access to underserved populations by other forms of telemedicine should consider proposing a policy change to provide coverage for those services on a pilot basis to the state Medicaid administrators.

The enactment of the New Hampshire Telemedicine Act of 2009 guarantees coverage of telemedicine by private insurance providers for services subject to reimbursement in their policies for in person care. The state Insurance Department has yet to release written guidelines. Providers and consumers are encouraged to ask their insurance providers for their operational policies on reimbursement in the interim.

We highly recommend that any community health center seeking to serve as the originating site for telemedicine services 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.

The NorthEast Telehealth Resource Center (NETRC) is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number G22RH22699 (Telehealth Resource Center Grant Program, Office for the Advancement of Telehealth in the amount of \$325,000). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.