NORTHEAST TELEHEALTH RESOURCE CENTER

Maine Telemedicine Reimbursement Guide

By Michael Edwards and Kim Mohan; October 2014

Maine has a very favorable environment with respect to reimbursement for health care services delivered by telemedicine. Nevertheless, there are many complexities to consider when planning to implement a telemedicine program.

Find information on each insurer see:

Medicare...Page 1
MaineCare (Maine's Medicade Program).....................Page 5
Private Insurance...Page 8

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 in an MSA county, 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

In Maine, all sites in 12 entirely rural counties are eligible, and within counties encroached by MSAs (Cumberland, York, Androscoggin, and Penobscot) certain rural census tracts are eligible under the new interpretation.

Limitations and exclusions

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

Qualified services

Each year new procedures are added to the list of qualified services. This is the 2014 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 – 15
Initial inpatient consultations at hospital, emergency room, or skilled nursing facility sites, where the provider is not the physician of record	G0425 – 7
Follow-up inpatient consultations	G0406 – 8
Subsequent hospital care services, with the limitation of one telehealth visit every 3 days	99231 – 3
Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days	99307 – 10
Psychiatric diagnostic interview examination	90791, 90792
Individual psychotherapy	90832 - 4, 90836 - 8
Neurobehavioral status exam	90791, 90792
Psychoanalysis (*proposed for 2015*)	90845

Qualified Procedures—*continued*	CPT/ HCPCS Codes
Family therapy, without or with patient (*proposed for 2015*)	90846, 90847
Pharmacologic management	96116
Individual and group Diabetes Self-Management Training DSMT	90862
Individual and group medical nutrition therapy (MNT), when patient has diabetes or kidney disease	G0108 – 9
Individual and group kidney disease education (KDE)	G0270; 97802 – 4
End-stage renal disease (ESRD) related services, with a limitation that one visit be face-to-face to examine vascular access site	G0420 – 1
Individual and group health and behavior assessment and intervention (HBAI)	90951 - 2, 90954 - 5, 90957 - 8, 90960 – 1
Smoking and tobacco use cessation counseling visit	96150 – 4
Alcohol and/or substance other than tobacco abuse structured assessment (e.g., AUDIT, DAST) and brief intervention (15-30 min. or >30 min.)	G0396 – 7
Annual alcohol misuse screening	G0442
Brief face-to-face behavioral counseling for alcohol misuse	G0443
Annual depression screening	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 complexity	99485
Transitional care management services, high complexity	99496

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

- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Clinical nurse specialist
- Clinical
- 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 2014 (amount set each year in the *Medicare Physician Fee Schedule Final Rule*, as published in the November *Federal Register*).

Billing for other services delivered remotely not requiring telehealth coding:

In the 2014 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).*

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/

MAINECARE (MAINE'S MEDICAID PROGRAM)

Overview

MaineCare has reimbursed for telemedicine services for over 10 years. It follows closely the model for Medicare in restricting coverage to services delivered only through live, interactive sessions using two-way video and audio technology (videoconferencing). As in the case of Medicare, telemedicine services delivered to MaineCare patients must conform to those defined in the MaineCare Benefits Manual as covered services. Reimbursement rates are at par with in-person services. No facility fee for the originating site is instituted.

In some ways, the MaineCare program is more flexible than Medicare with respect to telemedicine. There are no specifications about eligible locations or facilities for the originating site, and all providers already approved to deliver MaineCare reimbursement for services and eligible to do so by telemedicine. However, the quality assurance responsibilities of the MaineCare administration leads them to mandate a detailed justification for service delivery by telemedicine, formal informed consent procedures, and a documented plan for assessment of patient satisfaction and outcomes.

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.

MaineCare does not reimburse for any charge related to the technical aspect of the telehealth service, for the use or upgrade of technology, transmission charges, and any charges for an attendant who instructs a patient or caretaker in the use of the equipment or supervises/monitors a patient during the telehealth encounter. It also does not pay for consultations between professionals only, when no patient is present.

The biggest limitation is that delivery of each specific type of service between a given provider and particular patient access site must be approved in advance on the basis of a written request that justifies a “compelling benefit” for the patient to receive services via telemedicine. As specified in the MaineCare Benefits Manual (Section 1.06):

The benefit must be related to physical, social or geographic issues that make delivering the service in person difficult. It must not be for the convenience of the provider. The member’s record must contain documentation that the member has met one or more of the criteria listed below:

a. Physical: A member’s medical condition makes a face-to-face encounter that entails significant travel inadvisable or impossible.
b. Social: The family or other support system does not support a member traveling a distance for a face-to-face encounter, or does not allow the member to take the time that travel will require.
c. Geographic: There is a lack of medical/psychiatric/mental health expertise locally, limited transportation resources, or a long wait for such local care.

When requesting approval to provide services via telehealth, providers must submit the following information to MaineCare (specified at: http://www.maine.gov/dhhs/oms/headline_news_details.shtml?id=615193):

1. *The names, provider numbers and licensure level of individual providers who utilize telehealth to provide services;*
2. *A list of the procedure codes that will be utilized;*
3. *A statement explaining the rationale for needing telehealth capabilities for the service(s) being proposed;*
4. *A statement explaining the specific criteria utilized in determining when telehealth services are more appropriate than face-to-face services;*
5. *A plan for quality assurance activities specifically related to patient satisfaction and outcomes related to telehealth service; and*
6. *Educational information that will be provided to the MaineCare member at the time of the member’s visit. This information should be written at a sixth grade comprehension level and at a minimum it should include the following information:*
    a. *Description of the telehealth equipment and what to expect;*
    b. *Explanation that the use of telehealth for this service is voluntary and that the same service is available in a face-to-face setting;*
    c. *Explanation that the member is able to stop the telehealth visit at any time and request a face-to-face service;*
    d. *Explanation that MaineCare will pay for transportation to a distant appointment if needed and;*
    e. *HIPAA compliance information regarding the telehealth encounter.*
7. *Any additional information determined by the Department as necessary to protect members and ensure the integrity of the program. Documentation must be sent to the Medical Director MaineCare Services, 11 State House Station, Augusta, ME 04333-0011. MaineCare Services will review this justification and, if in agreement, will send the provider a letter of approval that must be kept on file.*

Discussions between members of the Maine Telehealth Advisory Group and the MaineCare Medical Director in 2010 clarified that that the “quality assurance activities” noted above may correspond to one or two paragraphs describing how the provider will oversee and assure the quality of the program. Also, once a provider is approved to

deliver reimbursable services to a patient site, no further justification is required; however, there is the expectation that the medical record of each new patient should include the reasoning for why telemedicine is used.

Eligible originating sites (facility where patient is located)

This is not specified by the written policy, but it is clear that the justification of the telemedicine service and requirement for an effective quality assurance plan may make it hard to get approval for atypical patient origination sites. Also, home health agencies note that home health services delivered by telemedicine are not reimbursable by MaineCare.

Qualified services

This is open to any services covered by MaineCare, as long as the benefits to the patient in delivery by telemedicine is justified to the satisfaction of program administrators.

Eligible distant site providers

This is open to provider types whose regular face-to-face services are reimbursable by MaineCare. As specified above, they must already be approved for MaineCare services before seeking approval for their delivery by telemedicine.

Billing procedures

Services are to be billed in accordance with applicable sections of the MaineCare Benefits Manual. Providers must submit claims in accordance with Department 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 telehealth.

The Benefits Manual also includes the following relevant provisions:

- Providers must not bill for portions of a physical exam not actually performed by the rendering provider unless it is possible to actually confirm the finding via the telehealth equipment (i.e., visually or via auscultatory equipment of appropriate sensitivity).
- Services delivered via telehealth are held to the same standard of documentation as non-telehealth services.
- Each instance of telehealth service will require documentation as to why telehealth was utilized to deliver that service.

As of March 2012, an additional procedure was requested through the MaineCare listserv, namely the inclusion of the authorization letter from the MaineCare Medical Director for the particular provider and service to bill for telemedicine services. Organizations submitting paper claims should include a photocopy, whereas submissions by Electronic Data Interchange (EDI) or Direct Data Entry (DDE) should include an upload of an electronic copy of the authorization within the same day as the claim submission. This extra paperwork burden will hopefully be relieved in the future by automated procedures for identifying the approved provider within the Maine Integrated Health Management System database.

2014, the Maine State Legislature passed a resolve, LD1596, calling for DHHS to review and revise their MaineCare policy rules for services delivered by telehealth by October, 2014, with the expectation of cost savings in health care delivery. A draft of a revised policy was shared with the Maine Telehealth Forum stakeholder group for discussion and feedback. The most significant differences from current policy was a change in requiring pre-approval and demonstration of "compelling benefit" for telehealth delivery to coverage of "any medically necessary service …as long as service is of comparable quality."

Resources for further review and updates on MaineCare:

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

- MaineCare Benefits Manual, Chapter I, Section 1.06-2, p. 20 – 23 (http://www.maine.gov/sos/cec/rules/10/ch101.htm)

PRIVATE INSURANCE PROVIDERS

In 2009, Maine passed a new law that mandated private insurance coverage for delivery of services by interactive telemedicine. The law, "An Act to Provide for Insurance Coverage of Telemedicine Services" (Sec. 1. 24-A MRSA §2765) specifies that:

All individual health insurance policies, contracts and certificates 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.

Other sections extend the same language to group health insurance policies (2847-Q) and health maintenance organization plans (4257).

Limitations and exclusions

As with Medicare and MaineCare, eligible telemedicine services are those that employ live, interactive audio-visual sessions with the provider and does not include the use of audio-only telephone, facsimile machine or e-mail. CIGNA is an exception in that even before the telehealth law was passed they were open to covering services delivered by diverse electronic means, including telephone and e-mail, for geographically remote patients when deemed medically necessary.

Eligible originating sites (facility where patient is located)

This depends on the private insurance plan. Parity of telehealth services with the service provisions for in-person care is implied in the law.

For example, in the case of Anthem Blue Cross and Blue Shield, the following constitute eligible patient originating sites for in-person and telehealth based care alike:

- Provider's office
- Hospital
- Rural Health Clinic
- Federally Qualified Health Center

In the case of CIGNA, even before the law was passed, they had a policy of reimbursing for a broad range of telehealth services when deemed medically necessary. In a policy document, they embraced its use to enhance access to care:

> *…when there is no access to direct patient-provider interaction for healthcare services, such as in remote geographical areas or health professional shortage areas, telemedicine services may be of benefit and improve access to care.*

Qualified services

Again, any in-person services covered by the insurance provider should be covered when delivered by telemedicine.

Eligible distant site 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 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 network provider is used.

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 code must be used.

CIGNA 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.

Given that the statute makes no provisions for it, no insurance provider provides reimbursement for a "facility fee" to the organization hosting patient presentation (a feature of Medicare coverage).

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.

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 sites designated as Health Professional Shortage Areas.

Maine's reimbursement policy for its Medicaid program is more flexible in the geography of eligible sites of patient access and in the range of services covered. However, the implementation of telemedicine by a given provider to a particular originating site must be

pre-approved by the MaineCare administration. A revision in policy which relaxes this requirement seems likely by Fall 2014, in response to a request in a legislative resolve.

Private insurance provider coverage of services delivered by telemedicine is guaranteed under a 2009 law, subject to the same restrictions as apply to in-person services covered under the health care policy.

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.

We are eager to make corrections of any errors or omissions you may detect in this guide. We also encourage those who learn through experience any lessons you think others will find useful, please submit your discoveries to Michael Edwards at medwards@rmcl.org.