Telehealth Services Billing Overview

Kathy J. Chorba
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Mandated all payers develop a policy to pay for medical services provided via telemedicine.
Medi-Cal

- Pays full price for both sides of the consult - primary care office visit and the consultation.

- Must adhere to established guidelines regarding referring and specialty sites, approved billing codes, and usage of billing modifiers.
Medi-Cal Terminology

- **Distant Site** = location from where a physician or practitioner provides professional services via telecommunications

- **Originating Site** = location of an eligible recipient at the time service is furnished via telecommunications
  - Offices of physicians or practitioners
  - Critical access hospitals
  - Rural health clinics
  - Federally Qualified Health Centers
Medi-Cal Interactive Telemedicine
Reimbursable Services

- **Distant Site**: The following services are reimbursable when performed according to telemedicine guidelines and when billed with modifier GT (service rendered via interactive audio and telecommunications systems) and the appropriate CPT-4 code.
  - Psychiatric Codes
    - 90801, 90802, 90805-90819, 90821-90824, 90826-90829, 90853. Z0300
  - E&M Codes
    - 99201-99215, 99221-99233, and 99241-99275

- **Originating Site**: The originating site bills for a standard office visit, with no modifier.
Expanded Telemedicine Benefits

- Effective retroactively to July 1, 2008, telemedicine services have been expanded. In addition to billing an office visit if the PCP is present during the consult, the PCP can bill:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Transmission Site</th>
<th>Frequency Limit</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3014 – facility fee</td>
<td>Originating Site</td>
<td>Once per day Same recipient, same provider</td>
<td>$22.94</td>
</tr>
<tr>
<td>T1014 – transmission costs</td>
<td>Originating site and Distant site</td>
<td>Maximum of 90 min. per day (1 unit = 1 minute) Same recipient, same provider</td>
<td>24 cents per minute</td>
</tr>
</tbody>
</table>
Medi-Cal Store and Forward Dermatology and Ophthalmology Reimbursable Services

- Services provided via store and forward telecommunications system must be billed with modifier GQ (service rendered by store-and-forward telecommunications system). Only the portion(s) rendered from the **distant site (hub)** are billed with modifier GQ.
- Services provided at the **originating site (face-to-face)** with the patient during service that will be provided by store and forward transaction are billed according to standard Medi-Cal practices (without a GQ modifier).
<table>
<thead>
<tr>
<th>CPT-4 Code</th>
<th>E&amp;M Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241-99243</td>
<td>Office consultation, new or established patient</td>
</tr>
<tr>
<td>99251-99253</td>
<td>Initial inpatient consultation</td>
</tr>
<tr>
<td>99211-99214</td>
<td>Office or other outpatient visit</td>
</tr>
<tr>
<td>99231-99233</td>
<td>Subsequent hospital care</td>
</tr>
</tbody>
</table>
Medi-Cal Store and Forward

*Important item to consider*

- A patient receiving teleophthalmology or teledermatology by store-and-forward shall be notified of the right to receive interactive communication with the distant specialist physician consulted through store-and-forward, upon request. If requested, communication with the distant specialist physician may occur either at the time of consultation or within 30 days of the patient’s notification of the results of the consultation.
FQHC Telehealth Reimbursement Models
FQHC Patient Site to Medi-Cal Specialist

**SCENARIO 1**

Patient is physically present at FQHC
Specialist is a Medi-Cal provider not physically present at the FQHC
FQHC and Medi-Cal specialist have agreement to provide services, but FQHC does not compensate the specialist
No medical reason for a provider to be present with the patient at the FQHC site
Patient ‘virtually’ enters specialist site via telemedicine

**OUTCOMES**

Medi-Cal specialist is the provider site, and can bill fee-for-service rate.
FQHC did not provide a medical service and cannot bill PPS for a face-to-face visit.

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\[ FQHC \text{ PPS sites are not eligible to bill an originating site fee, or transmission charges; the costs of these services should be accounted for in the PPS rate calculation.} \]
FQHC Patient Site with Provider Present to Medi-Cal Specialist

**SCENARIO 1A**

- Patient is physically present at the FQHC
- Specialist is a Medi-Cal provider not physically present at the FQHC
- FQHC and Medi-Cal specialist have agreement to provide services, but FQHC does not compensate the specialist
- Medical reason for a provider to be present with patient at the FQHC site
- Patient 'virtually' enters specialist site via telemedicine

**OUTCOME**

- Medi-Cal specialist is the provider site and can bill fee-for-service rate.
- FQHC provided a medically necessary service, thus also a provider site, and can bill PPS for a face-to-face visit.

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*Telemedicine services do not change or modify other FQHC billing provisions, including any current limits on patient visit frequency.*
FQHC Patient Site to FQHC Specialist Site

**SCENARIO 2**

Patient is physically present at FQHC 1  
Specialist is physically present at and receives compensation from FQHC 2  
FQHC 1 and FQHC 2 have agreement to provide services, but FQHC 1 does not compensate FQHC 2  
No medical reason for a provider to be present with the patient at the FQHC site  
Patient 'virtually' enters FQHC 2 site via telemedicine

**OUTCOMES**

FQHC 2 is the provider site, and can bill PPS for a face-to-face visit.  
FQHC 1 did not provide a medical service and cannot bill PPS for a face-to-face visit.
**SCENARIO 2A**

- Patient is physically present at FQHC 1
- Specialist is physically present and receives compensation from FQHC 2
- FQHC 1 and FQHC 2 have an agreement to provide services, but FQHC 1 cannot compensate FQHC 2
- Medical reason for a provider to be present with patient at the FQHC site
- Patient 'virtually' enters specialist site via telemedicine

**OUTCOME**

- FQHC 2 specialist is the provider site, and can bill PPS for a face-to-face visit.
- FQHC 1 provided a medically necessary service, thus also a provider site, and can also bill PPS for a face-to-face visit.

*Telemedicine services do not change or modify other FQHC billing provisions, including any current limits on patient visit frequency.*
**SCENARIO 3**

Patient is physically present at a Medi-Cal (Fee-for-Service) Site  
Specialist is physically present at and receives compensation from FQHC  
Medi-Cal Site and FQHC have agreement to provide services, but Medi-Cal Site does not pay FQHC  
No medical reason for a provider to be present with the patient at the Medi-Cal site  
Patient ‘virtually’ enters FQHC site via telemedicine

**OUTCOMES**

FQHC is the provider site, and can bill PPS for a face-to-face visit.  
Medi-Cal Site did not provide a medical service and cannot bill for a visit, but is eligible for site fee and transmission charges under Medi-Cal.
FQHC Patient Site to Other Specialist Site

**SCENARIO 4**

Patient is physically present at FQHC  
Specialist is not physically present at the FQHC  
FQHC and Specialist have an agreement to provide services, and FQHC compensates specialist.  

The agreement should be in writing and clearly state: the time period during which the agreement is in effect; the specific services it covers; any special conditions under which the services are to be provided; and the terms and mechanisms for billing and payment. (See BPHC Policy Information Notice 96-23)  
Provider 'virtually' enters 'four walls' of FQHC via telemedicine

**OUTCOME**

FQHC becomes the provider site, and can bill PPS for a face-to-face visit.

Because an FQHC's specialist's time is accounted for in the FQHC's PPS rate, an FQHC cannot contract to receive additional compensation from another FQHC or other patient site. See Scenarios 2 and 2a for appropriate reimbursement models.

*Teledmedicine services do not change or modify other FQHC billing provisions, including any current limits on patient visit frequency.
Private Payers

- Follow MediCal in that they pay for both ends of the consult.
  - Modifiers may be different (and in some cases, not existent)
Medicare

- Pays for both sides of the consult – full price for the consultation, limited reimbursement for the primary care office visit.

- Must adhere to established guidelines regarding referring and specialty sites, approved billing codes, usage of billing modifiers
Medicare Terminology

• **Originating Site** = location of an eligible Medicare beneficiary at the time the service being furnished via telecommunications system occurs

• **Distant Site** = location from where a physician or practitioner provides professional services via telecommunications
Medicare Reimbursement Checklist
Telehealth Originating Site Facility Fee
January 2012

In order for a defined eligible originating site to bill Medicare for facility fee related to an eligible telehealth encounter, each of the boxes must be checked.

☐ The patient was seen from one of the following “originating sites”

- The office of a physician or practitioner
- Hospital-based or critical access hospital-based renal dialysis center (including satellites)
- Critical access hospital
- Skilled nursing facility
- Community mental health center
- Hospital
- Federally qualified health center
- Rural health clinic

☐ The encounter was performed at the distant site by one of the following:

- Physician
- Nurse Midwife
- Clinical Psychologist
- Registered Dietician or Nutrition Professional
- Nurse Practitioner
- Physician Assistant
- Clinical Nurse Specialist
- Clinical Social Worker

☐ The patient was present and the encounter involved interactive audio and video telecommunications, that provides real-time communication between the practitioner and the Medicare beneficiary.

☐ The Medicare beneficiary resides in, or utilizes the telemedicine system in federally designated rural Health Professional Shortage Area (HPSA), in a county that is not included in a Metropolitan Statistical Area; or from an entity that participates in a federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.
**Medicare Reimbursement Checklist**

**Telehealth Originating Site Facility Fee**

January 2012

☐ The encounter involved one of the following CPT codes:

<table>
<thead>
<tr>
<th>Telehealth Services:</th>
<th>CPT/HCPCS Codes</th>
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<th>CPT/HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient Consultations&quot;</td>
<td>G0425 – G0427</td>
<td>End Stage Renal Disease (ESRD) related services&quot;</td>
<td>90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961</td>
</tr>
<tr>
<td>Office or other out-patient visits</td>
<td>99201 - 99215</td>
<td>Neurobehavioral Status Exam</td>
<td>96116</td>
</tr>
<tr>
<td>Psychiatrist diagnostic interview examination</td>
<td>90801</td>
<td>Follow-up in-patient telehealth consultations&quot;</td>
<td>G0406, G0407, G0408</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>90804 - 90809</td>
<td>Health and Behavioral Assessment and Intervention Services (HBAI)</td>
<td>96150 - 69152</td>
</tr>
<tr>
<td>Individual Medical Nutrition Therapy</td>
<td>G0270, 97802, 97803</td>
<td>Group HBAI services (two or more patients)</td>
<td>96153</td>
</tr>
<tr>
<td>Group Medical Nutrition Therapy (MNT)</td>
<td>97804</td>
<td>Group HBAI services (family with the patient present)</td>
<td>96154</td>
</tr>
<tr>
<td>Individual Kidney Disease Education (KDE) services</td>
<td>G0420</td>
<td>Individual Diabetes Self-Management Training (DSMT)&quot;</td>
<td>G0108</td>
</tr>
<tr>
<td>Group Kidney Disease Education (KDE) services</td>
<td>G0421</td>
<td>Group Diabetes Self-Management Training (DSMT)&quot;</td>
<td>G0109</td>
</tr>
<tr>
<td>Pharmacologic management</td>
<td>90862</td>
<td>Subsequent hospital care services&quot;</td>
<td>99231, 99232, 99233</td>
</tr>
<tr>
<td>Smoking Cessation Services</td>
<td>99406, G0436, G0437</td>
<td>Subsequent nursing facility care services&quot;</td>
<td>99307, 99308, 99309, 99310</td>
</tr>
</tbody>
</table>
Medicare Reimbursement Checklist
Telehealth Originating Site Facility Fee
January 2012

If all of the boxes are checked, you may submit a claim to Medicare and the following must occur:

- To receive the facility payment, submit claims with HCPCS code “Q3014 telehealth originating site facility fees.” Short description “telehealth facility fee.” For CY 2012, the facility fee is 80 percent of the lesser of the actual charge or $24.24.
- The type of service for telehealth originating site facility fee is “9, other items and services.”

IMPORTANT NOTE: There are various caveats to the originating site facility fee payments. Each billing department should receive the May 1, 2011 CMS Program Memorandum for the details in the section entities Originating Site Facility Fee Payment Methodology.

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1 As defined in statute, an “originating site” is where the patient is located, and “distant site” is where the health care provider is located.

2 CMS deleted CPT codes 99241-99245 (office/out-patient consultation) and codes 99251-99255 (initial in-patient consultation). Thus, effective January 1, 2010, these CPT codes are no longer reimbursable for in-patient or out-patient telehealth visits.

3 For ESRD related services, at least one face-to-face, “hands on” visit (non-telehealth-related) must be furnished each month to examine the vascular access site by a physician, NP, PA, or CNS.

4 Effective January 1, 2010, these CPT codes are also billable for telehealth services furnished to beneficiaries in an in-patient hospital setting or skilled nursing facility.

5 Individual DST services include an associated requirement of a minimum of one hour, in-person instruction to be furnished in the year following the initial DSMT service to ensure effective injection training.

6 Group DSMT services include an associated requirement of a minimum of one hour, in-person instruction to be furnished in the year following the initial DSMT service to ensure effective injection training.

7 Subsequent hospital care services, with the limitation for the patient’s admitting practitioner of one telehealth visit every three days.

8 Subsequent nursing facility care services, with the limitation for the patient’s admitting practitioner of one telehealth visit every 30 days.

This document does not constitute legal advice and is intended only as an educational guide to assist telehealth providers in evaluating whether a particular service could be reimbursed by the Medicare program. Many factors affect the appropriate use of submitting a particular claim for reimbursement. Even if your contemplated telehealth service appears to be consistent with the requirements in this checklist, you should consult with your billing specialist or attorney prior to initiating a new line of Medicare claims.
Medicare Reimbursement Checklist
Telehealth Professional Fee
January 2012

To bill Medicare for professional fees for telehealth encounters or consultations, each of the boxes must be checked.

☐ The patient was seen from one of the following "originating sites":

- The office of a physician or practitioner
- Hospital-based or critical access hospital-based renal dialysis center (including satellites)
- Critical access hospital

- Skilled nursing facility
- Community mental health center
- Hospital
- Federally qualified health center
- Rural health clinic

☐ The encounter was performed at the distant site by one of the following:

- Physician
- Nurse Midwife
- Clinical Psychologist
- Registered Dietician or Nutrition Professional

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☐ The patient was present and the encounter involved interactive audio and video telecommunications, that provides real-time communication between the practitioner and the Medicare beneficiary.

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Telehealth Professional Fee
January 2012

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<td>Pharmacologic management</td>
<td>90862</td>
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Medicare Reimbursement Checklist

Telehealth Professional Fee

January 2012

If all of the boxes are checked, you may submit a claim to Medicare and the following must occur:

- Beneficiary is responsible for coinsurance and deductible payments.
- Amount of reimbursement cannot exceed the current fee schedule of the consultant/practitioner.
- Beneficiaries may not be billed directly for any facility or telecommunications charges.
- These codes must be billed with a modifier of “GT” for interactive audio and video telecommunications system, or “GQ” for asynchronous telecommunications system.

IMPORTANT NOTE: X-rays, diagnostic ultrasound, electrocardiogram, electroencephalogram, and cardiac pacemaker analysis are all covered regardless of the criteria at the top of this page. These are services that do not normally require in-person interaction between provider and patient.

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Billing Resources

The Telemedicine Reimbursement Handbook

Contents
- Medi-Cal Training Seminars
- Outpatient and Medical Crossover
  - Claims Billing Update
- Reimbursement for Second Assistant Surgeon Update
- Physician Assistant Services Expanded
- Abatacept Injection Policy Update
- Secretin Injection Update
- Pediatric Combination Vaccine
  - New Benefit
- Rabies Biologics Update
- Bortezomib (Velcade)
  - Policy Update
- Expanded Telemedicine Benefits
- Billing Code Changes for
  - Chemotherapy Drugs
  - Irinotecan and Leucovorin
- Calcium
- HCPCS code J9310
- Requirements Update
- Cataract Postoperative Care
  - Billing Guidelines
- “One Time Drug Fill” Language
  - Removed from Part 2 Manual
- Family PACT Provider Orientation
  - and Update Sessions
- National Drug Code (NDC)
  - Reporting Requirements
- CCS Physician Services Supplemental
  - Rate Increase for Physician-Only
  - Service Components
- Maximum Reimbursement Rates
  for Pathology Codes
- Utilization of Zolpidem in
  New Start Recipients

The “Telemedicine Act of 1996” made the practice of telemedicine a legitimate means by which an
individual may receive medical services from a health care practitioner without physically being in the same location as the provider. This legislation allows health care practitioners to:  
- improve patient access to health care services;  
- improve health service delivery in medically underserved rural areas or areas where geographic barriers restrict access.

In order for a defined eligible or new start recipient to receive services through telemedicine, each eligible telehealth encounter, each eligible or new start recipient must:  
- The patient was seen from on-site and:  
  - The office of a physician or surgeon
  - Hospital-based or critical access hospital-based renal dialysis (including satellites)
  - Critical access hospitals
- The encounter was performed by:  
  - Physician
  - Nurse Midwife
  - Clinical Psychologist
  - Registered Dietician or Nutrition Professional
- The patient was present at the telecommunications, that provided and the Medicare beneficiary.

The Medicare beneficiary reside in a rural Health Professional Shortage Area (HPSA) or in a Medicare-defined rural area (MDRA) and:  
- The patient was seen from on-site and
  - The office of a physician or surgeon
  - Hospital-based or critical access hospital-based renal dialysis (including satellites)
  - Critical access hospitals

 effective for dates of service on or after November 1, 2008, reimbursement for a procedure performed through telemedicine, whether from California or out of state, must be licensed in the state where the service was performed telemedically.
Telehealth Services Billing Overview

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