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# Program Memorandum Intermediaries/Carriers

Department of Health and  
Human Services (DHHS)  
HEALTH CARE FINANCING  
ADMINISTRATION (HCFA)

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## CHANGE REQUEST 1650

### **SUBJECT: Revision of Medicare Reimbursement for Telehealth Services**

This Program Memorandum (PM) contains policy and billing instructions implementing §223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) - Revision of Medicare Reimbursement for Telehealth Services. BIPA amended §1834 of the Social Security Act (the Act) to provide for an expansion of Medicare payment for telehealth services.

**Section 223 of BIPA limits the existing telehealth provision to services furnished before October 1, 2001, and mandates that the expanded benefit be effective for services furnished on or after October 1, 2001. Therefore, this benefit expansion is being implemented via a PM. Conforming regulation text changes will follow this instruction.**

### **Summary**

Effective October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy and pharmacologic management delivered via a telecommunications system. Eligible geographic areas will be expanded beyond rural health professional shortage areas to include counties not in a metropolitan statistical area (MSA). Additionally, Federal telemedicine demonstration projects as of December 31, 2000, may serve as the originating site regardless of geographic location. An interactive telecommunications system is required as a condition of payment; however, BIPA does allow the use of asynchronous 'store and forward' technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. BIPA does not require that a practitioner present the patient for interactive telehealth services.

With regard to payment amount, BIPA specifies that payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at time of telemedicine encounter) will be equal to what would have been paid without the use of telemedicine. Distant site practitioners include only a physician as described in §1861(r) and a medical practitioner as described in §1842(b)(18) (C) of the Act. BIPA also expands payment under Medicare to include a \$20 originating site facility fee (location of beneficiary).

Previously, the Balanced Budget Act of 1997 (BBA) limited the scope of Medicare telehealth coverage to consultation services and the implementing regulation prohibited the use of an asynchronous, 'store and forward' telecommunications system. BBA 1997 also required the professional fee to be shared between the referring and consulting practitioners, and prohibited Medicare payment for facility fees and line charges associated with the telemedicine encounter.

BIPA requires that Medicare Part B (Supplementary Medical Insurance) pay for this expansion of telehealth services beginning with services furnished on October 1, 2001.

Time limit for current teleconsultation provision The current teleconsultation provision as authorized by §4206 (a) and (b) of the BBA of 1997 and implemented in 42 CFR §§410.78 and 414.65 applies only to teleconsultations provided on or after January 1, 1999, and before October 1, 2001.

## Expansion of Medicare Payment for Telehealth Services

### Eligibility Criteria

Beneficiaries eligible for telehealth services. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in either a rural health professional shortage area (HPSA) as defined by §332(a)(1) (A) of the Public Health Services Act or in a county outside of a MSA as defined by §1886(d)(2)(D) of the Act.

Exception to rural HPSA and non MSA geographic requirements. Entities participating in a Federal telemedicine demonstration project that were approved by or were receiving funding from the Secretary of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location. Such entities are not required to be in a rural HPSA or non-MSA.

Originating site defined. An originating site is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Originating sites authorized by law are listed below.

- The office of a physician or practitioner.
- A hospital.
- A critical access hospital.
- A rural health clinic.
- A federally qualified health center.

### Coverage of Telehealth

Scope of coverage. The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy and pharmacologic management. These services and corresponding current procedure terminology (CPT) codes are listed below.

- Consultations (CPT codes 99241 - 99275).
- Office or other outpatient visits (CPT codes 99201 - 99215).
- Individual psychotherapy (CPT codes 90804 - 90809).
- Pharmacologic management (CPT code 90862).

### Conditions of Payment

Technology. For Medicare payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.

Exception to the interactive telecommunications requirement. In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, Medicare payment is permitted for telemedicine when asynchronous 'store and forward technology', in single or multimedia formats, is used as a substitute for an interactive telecommunications system. The originating site and distant site practitioner must be included within the definition of the demonstration program.

Store and forward defined. For purposes of this instruction, store and forward means the asynchronous transmission of medical information to be reviewed at a later time by physician or practitioner at the distant site. A patient's medical information may include, but not limited to, video clips, still images, x-rays, MRIs, EKGs and EEGs, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time.

**NOTE:** Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients' condition and adequate for rendering or confirming a diagnosis and or treatment plan. Dermatological photographs, e.g., a photograph of a skin lesion, may be considered to meet the requirement of a single media format under this instruction.

Telepresenters. A medical professional is not required to present the beneficiary to physician or practitioner at the distant site unless medically necessary. The decision of medical necessity will be made by the physician or practitioner located at the distant site.

### **Payment Methodology for Physician/Practitioner at the Distant Site**

Distant site defined. The term “distant site” means the site where the physician or practitioner, providing the professional service, is located at the time the service is provided via a telecommunications system.

Payment amount (professional fee). The payment amount for the professional service provided via a telecommunications system by the physician or practitioner at the distant site is equal to the current fee schedule amount for the service provided. Payment for an office visit, consultation, individual psychotherapy or pharmacologic management via a telecommunications system should be made at the same amount as when these services are furnished without the use of a telecommunications system. For Medicare payment to occur, the service must be within a practitioner’s scope of practice under State law. The beneficiary is responsible for any unmet deductible amount and applicable coinsurance.

Medicare practitioners who may receive payment at the distant site (i.e., at a site other than where beneficiary is). As a condition of Medicare Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under State law. When the physician or practitioner at the distant site is licensed under State law to provide a covered telehealth service (i.e., professional consultation, office and other outpatient visits, individual psychotherapy, and pharmacologic management) then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

Medicare practitioners who may bill for covered telehealth services are listed below (subject to State law).

- Physician.
- Nurse practitioner.
- Physician assistant.
- Nurse midwife.
- Clinical nurse specialist.
- Clinical psychologist.\*
- Clinical social worker.\*

\*Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.

### **Originating Site Facility Fee Payment Methodology**

Originating site defined. The term originating site means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii.

Facility fee for originating site. For consultation, office or other outpatient visit, psychotherapy and pharmacologic management services delivered via a telecommunications system furnished from October 1, 2001, through December 31, 2002, the originating site fee is the lesser of \$20 or the actual charge. For services furnished on or after January 1 of each subsequent year, the facility fee for the originating site will be updated annually by the Medicare Economic Index (MEI).

Payment amount. For telehealth services furnished from October 1, 2001, through December 31, 2002, the payment amount to the originating site is the lesser of the actual charge or the originating site facility fee of \$20. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance. The originating site facility fee payment methodology for each type of facility is clarified below.

- Hospital outpatient department. When the originating site is a hospital outpatient department, payment for the originating site facility fee must be made as described above and not under the outpatient prospective payment system. Payment is not based on current fee schedules or other payment methodologies.
- Hospital inpatient. For hospital inpatients, payment for the originating site facility fee must be made outside the Diagnostic related group (DRG) payment, since this is a Part B benefit, similar to other services paid separately from the DRG payment, (e.g., hemophilia blood clotting factor).
- Critical access hospitals. When the originating site is a critical access hospital, make payment as described above, separately from the cost-based reimbursement methodology.
- Federally qualified health centers (FQHCs) and rural health clinics (RHCs). The originating site facility fee for telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.
- Physicians' and practitioners' offices. When the originating site is a physician's or practitioner's office, the payment amount, in accordance with the law, is the lesser of the actual charge or \$20 regardless of geographic location. Do not apply the geographic practice cost index (GPCI) to the originating site facility fee. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the physician fee schedule.

## **Submission of Telehealth Claims**

### **Carrier and Intermediary Instructions**

Carriers and intermediaries must publish information concerning the changes outlined in this PM in their next regularly scheduled bulletin as well as on their websites.

#### *Professional Service - Carriers*

Distant site practitioners. Claims for professional consultations, office visits, individual psychotherapy, and pharmacologic management provided via a telecommunications systems for dates of service October 1, 2001, and later must be submitted to the carriers that processes claims for the practitioners service area. Submit such claims with the appropriate CPT code for the professional service provided and the telehealth modifier "GT" – "via interactive audio and video telecommunications system."

By using the "GT" modifier to bill for the telehealth service, the distant site practitioner verifies that the beneficiary was located at an eligible originating site at the time of the telehealth service.

Exception for store and forward (non-interactive) telehealth. In the case of a Federal telemedicine demonstration program conducted in Alaska or Hawaii, store and forward technologies may be used as a substitute for an interactive telecommunications system. When store and forward technologies are used, submit the appropriate CPT code and telehealth modifier "GQ", "via asynchronous telecommunications system."

(See "Store and forward defined" and "Medical practitioners who may receive payment at the distant site" sections).

By using the "GQ" modifier, the distant site practitioner verifies that the asynchronous medical file was collected and transmitted to the physician or practitioner at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii. (See "Eligibility Criteria" and "Conditions of Payment" sections.)

#### *Originating Site Facility Fee - Carriers and Intermediaries*

To receive the facility payment, submit claims with HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." The type of service for the telehealth originating site facility fee is "9, other items and services."

By submitting “Q3014” HCPCS code, the originating site authenticates they are located in either a rural HPSA or non-MSA county.

The facility fee will be updated yearly based upon the Medicare economic index and will be announced in an annual PM for carriers and intermediaries. Carriers and intermediaries must use these fees to pay the correct amount for this service. The Medicare physician fee schedule database will indicate that this claim is carrier-priced. This process is similar to the process currently used for the payment of certain mammography services.

Physicians’ and practitioners’ offices must bill the appropriate Medicare carrier for the originating site facility fee.

Intermediary claims processing. The appropriate bill types for this benefit are: 12X, 13X, 71X, 73X, and 85X. The originating site can be located in a number of revenue centers within a facility, such as an emergency room (450), operating room (360), or clinic (510). Instruct your providers to report this service under the revenue center where the service was performed and include HCPCS code “Q3014, telehealth originating site facility fee.”

Note that the originating site facility fee is a Part B payment. Pay the originating site facility fee outside of current fee schedules or other payment methodologies (e.g., payment must be made in addition to the DRG, outpatient prospective payment system.) (See “Originating site facility fee payment methodology”.)

Hospitals and critical access hospitals bill their intermediary for the originating site facility fee. Independent and provider-based RHCs and FQHCs bill the appropriate intermediary using the RHC or FQHC bill type and billing number. HCPCS code “Q3104, telehealth originating site facility fee” is the only non-RHC/FQHC service that is billed using the clinic/center bill type and provider number. For all other non-RHC/FQHC services, provider based RHCs and FQHCs must bill using the providers bill type and billing number. Independent RHCs and FQHCs must bill the carrier for all other non-RHC/FQHC services.

If an RHC/FQHC visit occurs on the same day as a telehealth service, the RHC/FQHC serving as an originating site must bill for HCPCS code “Q3014 telehealth originating site facility fee” on a separate revenue line from the RHC/FQHC visit.

The telehealth professional service payment and originating site facility fee are subject to post payment verification.

### **Carrier Editing of Telehealth Claims**

Carriers must install edits effective for dates of service October 1, 2001, and later to ensure that only providers approved to bill for these telehealth services are paid. Use the following information to develop edits for telehealth claims:

#### **Professional Service**

When the “GT” modifier or the “GQ” modifier is billed for dates of service October 1, 2001, and later with CPT codes 99241 - 99275, 99201 - 99215, 90804 - 90809, or 90862; process the claim only when the physician or practitioner is licensed to provide the service under State law. Carriers must review the State licensure provisions of States for which they process claims, and disallow any claims from practitioners who are not authorized the applicable covered telehealth service under State law. For example, if a nurse practitioner is not licensed to provide individual psychotherapy under State law, he or she would not be permitted to receive payment for individual psychotherapy under Medicare.

If a carrier receives professional claims with the "GQ" modifier representing "via asynchronous telecommunications system", deny claims from physicians or practitioners who are not affiliated with a Federal telemedicine demonstration conducted in Alaska or Hawaii. Carriers may require the physician or practitioner at the distant site to document his or her participation in a Federal telemedicine demonstration program conducted in Alaska or Hawaii prior to paying for telehealth services provided via asynchronous, store and forward technologies.

For services for which claims are denied because the provider may not bill for the service, use MSN message 21.18: "This item or service is not covered when performed or ordered by this practitioner." Carriers must use remittance advice message 52 when denying the claim based upon MSN message 21.18.

If professional service codes are submitted with one of the telehealth modifiers and the service is not considered a consultation, office or other outpatient visit, individual psychotherapy or pharmacologic management use MSN message 9.4: "This item or service was denied because information required to make payment was incorrect. Remittance advice message depends on what is incorrect, e.g., B18 if procedure code or modifier is incorrect, 125 if submission billing error, 4-12 for difference inconsistencies." Carriers must use B18 as the explanation for the denial of the claim.

### **Enrollment**

This PM does not affect Medicare enrollment. The physician or practitioner at the distant site and the originating site facility are not subject to separate enrollment procedures for telehealth.

**The *effective date* for this PM is October 1, 2001**

**The *implementation date* for this PM is October 1, 2001**

**These instructions should be implemented within your current operating budget.**

**This PM may be discarded after May 1, 2002.**

**If you have any questions, contact your regional office.**