STROUDWATER

[Blog] Lights, Camera, Telehealth! Episode 3: How Does Medicare Reimburse for Telemedicine?

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Regulations around payment for telehealth are variable and dynamic.

Medicare has expanded the list of reimbursable telemedicine services in recent years, but there are still restrictions on how each of these services can be provided. The restrictions can be broken out into four main categories:

1. **Type of telehealth service:** Currently, Medicare only reimburses for real-time telehealth services, with the exception of Hawaii and Alaska where they also reimburse for store-and-forward due to the remote geography.
2. **Provider:** Providers that are reimbursed for telehealth services under Medicare are physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologists, clinical social workers, and registered dietitians or nutrition professionals.
3. **Site of service:** For Medicare to reimburse for telehealth, the service must be performed at a specific site. The site must be a Health Professional Shortage Area (HPSA) or outside a metropolitan statistical area (MSA) (i.e., rural), and must be classified as a hospital, critical access hospital (CAH), rural health center (RHC), physician office, skilled nursing facility, community mental health center, federally qualified health center (FQHC), or hospital-based or CAH-based renal dialysis center. On top of the fee for service that is reimbursed, Medicare will also reimburse the originating site a facility fee. For example:
    - If a primary care provider at a small clinic with a patient in his or her office chooses to do a real-time telemedicine visit to consult another physician in another location, the clinic can bill Medicare for two services: the telemedicine service that was delivered and the facility fee for using their small clinic to "host" the patient visit.[1]
4. **Billing and CPT Codes:** Effective January 1, 2018, CMS eliminated the use of the GT modifier (a modifier that is used for interactive audio and telecommunications system visits). Instead, practitioners are supposed to report telehealth under POS (Place of Service) Code "02." The POS code does not apply to the originating sites billing the facility fee. HCPCS code Q3014 is the code used for the telehealth originating-site facility fee. Medicare has a specific list of current procedural terminology (CPT) and healthcare common procedure coding system (HCPCS) codes that are covered under telemedicine services.[2] GQ modifier (modifier used for asynchronous telecommunication system visits) is still required when applicable.

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[1] "The Ultimate Telemedicine Guide | What Is Telemedicine?" *EVisit® Telemedicine Solution*, EVisit LLC. https://evisit.com/resources/what-is-telemedicine/. Accessed July 2018.

[2] Lacktman, Nathaniel. "Telehealth Billing Compliance: Medicare Says Goodbye to the GT Modifier" *Telemedicine Magazine, 2018.* http://www.telemedmag.com/article/telehealth-billing-compliance-medicare-says-goodbye-gt-modifier/. Accessed July 2018.

Several provisions of the CHRONIC Care Act of 2018 helped broaden the use of telehealth services. The law expands telehealth coverage under Medicare Advantage Plan B beginning in 2020; eliminates the geographic restriction on telestroke consultation services beginning in 2019; and gives ACOs more flexibility to use telehealth services.[3]

To see the list of telemedicine services Medicare currently recognizes and to learn if any of your current services could be provided via telemedicine, refer to CMS's February 2018 publication.

In next week's blog, learn how Medicaid is recognizing and paying for telemedicine.

[3] Wicklund, Eric. "Telehealth, telemedicine Reimbursement Score Big in New Budget Deal." *Xtelligent Media, LLC*. https://mhealthintelligence.com/news/telehealth-telemedicine-reimbursement-score-big-in-new-budget-deal. Accessed July 2018.