Medicare Telehealth Reimbursement Checklist Professional Fee

January 2013
(updated 7/14/2014)

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[i]”

• 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 must resides in, or utilizes the telemedicine system in: 1) a federally designated rural Health Professional Shortage Area (HPSA; 2) a county that is not included in a Metropolitan Statistical Area (MSA); or 3) 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.

CMS has provided regulatory definition of “rural HPSA” for purposes of determining eligibility for Medicare telehealth originating sites to include HPSAs located in rural census tracts, consistent with the Office of Rural Health Policy/Health Resources and Services Administration (HRSA).

HRSA has developed a tool that will help providers determine geographic eligibility for Medicare telehealth services. This locator checks both the HPSA and MSA designations.

To determine eligibility for this requirement, click here to check to check your site’s eligibility through
The HRSA Medicare Telehealth Payment Eligibility Analyzer:
http://datawarehouse.hrsa.gov/telehealthAdvisor/telehealthEligibility.aspx

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☐ The encounter involved one of the following CPT codes:

Telehealth Services:	CPT/HCPCS Codes	Telehealth Services:	CPT/HCPCS Codes
In-patient Consultations[ii]	*G0425 – G0427*	Follow-up in-patient telehealth consultations[iii]	*G0406, G0407, G0408*
Office or other out-patient visits	*99201 - 99215*	Health and Behavioral Assessment and Intervention Services (HBAI)	*96150 - 96152*
Psychiatrist diagnostic interview examination	*90791-90792*	Group HBAI services (two or more patients)	*96153*
Individual psychotherapy	*90832-90834 90836-90838*	Group HBAI services (family with the patient present)	*96154*
Individual Medical Nutrition Therapy	*G0270, 97802, 97803*	Individual Diabetes Self-Management Training (DSMT)[iv]	*G0108*
Group Medical Nutrition Therapy (MNT)	*97804*	Group Diabetes Self-Management Training (DSMT)[v]	*G0109*
Individual Kidney Disease Education (KDE) services	*G0420*	Subsequent hospital care services[vi]	*99231, 99232, 99233*
Group Kidney Disease Education (KDE) services	*G0421*	Subsequent nursing facility care services[vii]	*99307, 99308, 99309, 99310*
Inpatient Pharm-acological Management[viii]	*G0459*	Annual alcohol misuse screening (15 minutes)	*G0442*
Smoking Cessation Services	*99406, 99407, G0436, G0437*	Brief face-to-face behavioral counseling for alcohol misuse (15 mins)	*G0443*
Alcohol and/or substance abuse (other than alcohol) structured	*G0396 (15-30 minutes) G0397 (30 minutes +)*	Annual Depression Screening (15 minutes)	*G0444*
End Stage Renal Disease (ESRD) related services[ix]	*90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961*	High Intensity behavioral counseling to prevent sexually transmitted diseases	*G0445*
Neurobehavioral Status Exam	*96116*	Cardiovascular disease intensive behavior therapy	*G0446*
		Behavioral counseling for obesity	*G0447*

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 pace maker 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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[i] As defined in statute, an “originating site” is where the patient is located, and “distant site” is where the health care provider is located.

[ii] 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.

[iii] 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.

[iv] 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.

[v]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.

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

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

[viii] Effective CY 2013, “Pharmacological management” 90862 is deleted and replaced with E/M code. Inpatient Pharmacological Management (G0459) provides reimbursement for psychiatrists and prescribing psychologists and removes the frequency visit.

[ix] 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.

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 appropriateness 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.

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