Telehealth Reimbursement Resource Guide

With the use of telehealth to deliver care steadily increasing, understanding the functionality, limitations, coverage and best practices for telehealth billing are vital to maximizing reimbursement for providing these services.

Applications

Live Video
The form of telehealth most predominantly reimbursed for is live video - virtual provider to patient visits that use interactive audio and video telecommunications systems occurring in real-time.

Store-and-Forward
With store-and-forward telehealth, data such as medical images are saved and can be sent to the practitioner as needed. Reimbursement for this form of telehealth is much more limited since not occurring in live time.

Remote Patient Monitoring (RPM)
RPM uses a range of technological devices to monitor clinical signs of a patient remotely. Reimbursement for RPM is also limited due to the lack of a “face to face” visit.

Licensure
Currently, licensure restrictions exist that affect practitioners and their ability to participate in telehealth services. Although it varies by each state, most states require that a physician be licensed in the state in which the patient is located. These licensing restrictions limit coverage for practitioners who are provided telehealth services to patients in differing states.

Payers

Private/Commercial Insurance
Coverage for telehealth services and reimbursement from commercial payers varies by state. Some states have elected to mandate some level of reimbursement for telehealth visits, while others mandate telehealth coverage be equivalent to traditional, in-office services. Currently, 32 states and the District of Columbia have enacted parity laws that require private insurers to cover telehealth visits the same as in-person visits.
In states with parity law, most major insurance carriers provide coverage for some level of telehealth services, varying on type of plan or specific policy. These payers include Aetna, Blue Cross Blue Shield, Humana, Cigna, United Healthcare, and others.

**MEDICAID**
Similar to private insurance, reimbursement for telehealth services under Medicaid is administered differently by each state. States have the option whether to cover telehealth services or not, and the flexibility in deciding what services will be covered or excluded, what types of practitioners are eligible for reimbursement, and how much reimbursement will be provided under Medicaid. Currently, 48 state programs provide some level of reimbursement for telehealth visits that satisfy federal requirements of efficiency, economy and quality of care. The remaining two states do not currently have written definitive reimbursement policies for telehealth.

With the flexibility in reimbursement states are given, some states have adopted similar reimbursement criteria as Medicare while others have their own unique criteria. States may reimburse the practitioner at the distant site and also reimburse a facility fee to the originating site. States can also reimburse any additional costs such as technical support, transmission charges, and equipment. These add-on costs can be incorporated into the fee-for-service rates or separately reimbursed as an administrative cost by the state. If they are separately billed and reimbursed, the costs must be linked to a covered Medicaid service.
Medicare reimbursement for telehealth services is limited to a set of services if delivered services meet certain parameters:

**Originating Site:** In order to receive reimbursement for telehealth services, the patient must be located in (1) a rural Health Professional Shortage Area (HPSA) either located outside a Metropolitan Statistical Area (MSA) or in a rural census tract, or (2) a county outside of a MSA. The location where the patient receives care via telehealth is limited to:

- Physician offices
- Hospitals
- Critical Access Hospitals
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-based Renal Dialysis Centers
- Skilled Nursing Facilities
- Community Mental Health Centers

**Eligible Providers:** Medicare limits the type of practitioner who can receive reimbursement for providing telehealth services. This includes:

- Physicians
- Nurse practitioners
- Physician assistant
- Nurse-midwives
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinical psychologists
- Clinical social workers
- Registered dietitians and nutritionists

**Services Provided:** Coverage for telehealth under Medicare is limited to certain services, and permitted only if the visit is occurring in live time using interactive audio and video telecommunications systems and meets the criteria for medically necessary service. Asynchronous store-and-forward technology is only covered in Alaska or Hawaii. A complete and updated list of all eligible telehealth services can be found at [Centers for Medicare & Medicaid Services](https://www.cms.gov) website.

**PROFESSIONAL SERVICES FEE**

Claims for telehealth services furnished should be submitted using the appropriate CPT or HCPCS code for the professional service along with the modifier “GT”, “via interactive audio and video telecommunications systems”. By coding and billing the GT modifier with a covered telehealth procedure code, the practitioner is indicating that the patient was present at an eligible originating site at the time the telehealth service was furnished. For telehealth services in Alaska or Hawaii, claims should be submitted using the appropriate CPT or HCPCS code for the professional service along with the modifier “GQ”, “via an asynchronous telecommunications system”. By coding and billing the GQ modifier, the practitioner is verifying that the asynchronous medical file was collected and transmitted to him or her at the distant site. Medicare reimburses eligible practitioners with the appropriate amount under the Medicare Physician Fee Schedule (PFS) for telehealth services.
FACILITY FEE
In addition to the professional fees for the practitioner furnishing qualified telehealth services, the originating site is eligible for separate facility fees to offset the cost of the visit. To claim the facility payment, physicians should bill HCPCS Level II code Q3014. The service type for the telehealth originating site facility fee is 9 Other items and services. For carrier processed claims, the “office” place of service (POS) code 11 is the only payable setting for code Q3014. There is no participation payment differential for code Q3014, and it is not priced off of the Medicare Physician Fee Schedule. By submitting HCPCS Level II code Q3014, the biller certifies that the originating site is located in either a rural health provider shortage area (HPSA) or a non-metropolitan statistical area (MSA) county.

The telehealth originating site facility fee payment amount for CY 2016 is 80 percent of the lesser of the actual charge, or $25.10[1].

About Azalea Health
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