Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners Table of Contents (Rev. 4431, 11-01-19)

190 - Medicare Payment for Telehealth Services (Rev. 1, 10-01-03) A3-3497, A3-3660.2, B3-4159, B3-15516 190.1 - Background (Rev. 1635, Issued: 11-14-08, Effective: 01-01-09, Implementation: 01-05-09) Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) - Revision of Medicare Reimbursement for Telehealth Services amended §1834 (go to the link and then select the applicable title) of the Act to provide for an expansion of Medicare payment for telehealth services. 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 include rural health professional shortage areas (HPSA) and counties not classified as 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 specified 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) is equal to what would have been paid without the use of telemedicine. Distant site practitioners include only a physician as described in §1861(r) (go to the link and select the applicable title) of the Act and a medical practitioner as described in §1842(b)(18)(C) (go to the link and select the applicable title) of the Act. BIPA also expanded 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 required that Medicare Part B (Supplementary Medical Insurance) pay for this expansion of telehealth services beginning with services furnished on October 1, 2001. Section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended §1834 of the Act to add certain entities as originating sites for payment of telehealth services. Effective for services furnished on or after January 1, 2009, eligible originating sites include a hospital-based or critical access hospital-based renal dialysis center (including satellites); a skilled nursing facility (as defined in §1819(a) of the Act); and a community mental health center (as defined in §1861(ff)(3)(B) of the Act). MIPPA also amended§1888(e)(2)(A)(ii) of the Act to exclude telehealth services furnished under §1834(m)(4)(C)(ii)(VII) from the consolidated billing provisions of the skilled nursing facility prospective payment system (SNF PPS). NOTE: MIPPA did not add independent renal dialysis facilities as originating sites for payment of telehealth services. The telehealth provisions authorized by §1834(m) of the Act are implemented in 42 CFR 410.78 and 414.65. 190.2 - Eligibility Criteria (Rev. 2848, Issued 12-30-13; Effective 01-01-14; Implementation 01-06-14) 1. 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 an MSA as defined by §1886(d)(2)(D) (go to the link and select the applicable title) of the Act. Effective January 1, 2014, rural HPSAs include HPSAs located outside of a county outside of an MSA as well as those located in rural census tracts as determined by the Office of Rural Health Policy. Also effective January 1, 2014, geographic eligibility for an originating site is established for each calendar year based upon the status of the area as of December 31st of the prior calendar year. 2. 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 nonMSA. 3. 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. Originating sites authorized by law are listed below: The office of a physician or practitioner; A hospital (inpatient or outpatient); A critical access hospital (CAH); A rural health clinic (RHC); A federally qualified health center (FQHC); A hospital-based or critical access hospital-based renal dialysis center (including satellites) (effective January 1, 2009); A skilled nursing facility (SNF) (effective January 1, 2009); and A community mental health center (CMHC) (effective January 1, 2009). NOTE: Independent renal dialysis facilities are not eligible originating sites. For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii. 190.3 - List of Medicare Telehealth Services (Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16) The use of a telecommunications system may substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services. The various services and corresponding current procedure terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes are listed on the CMS website at www.cms.gov/Medicare/MedicareGeneral-Information/Telehealth/ NOTE: Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation CPT codes for payment of office/outpatient or inpatient visits. Instead, physicians and practitioners are instructed to bill a new or established patient office/outpatient visit CPT code or appropriate hospital or nursing facility care code, as appropriate to the particular patient, for all office/outpatient or inpatient visits. 190.3.1 - Telehealth Consultation Services, Emergency Department or Initial Inpatient versus Inpatient Evaluation and Management (E/M) Visits (Rev. 2354, Issued: 11-18-11 Effective: 01-01-12, Implementation: 01-03-12) A consultation service is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). It can involve an opinion, advice, recommendation, suggestion, direction, or counsel from a physician or qualified nonphysician practitioner (NPP) at the request of another physician or appropriate source. Section 1834(m) of the Social Security Act includes "professional consultations" in the definition of telehealth services. Inpatient or emergency department consultations furnished via telehealth can facilitate the provision of certain services and/or medical expertise that might not otherwise be available to a patient located at an originating site. The use of a telecommunications system may substitute for an in-person encounter for emergency department or initial and follow-up inpatient consultations. Medicare A/B MACs (B) pay for reasonable and medically necessary inpatient or emergency department telehealth consultation services furnished to beneficiaries in hospitals or SNFs when all of the following criteria for the use of a consultation code are met: • An inpatient or emergency department consultation service is distinguished from other inpatient or emergency department

evaluation and management (E/M) visits because it is provided by a physician or qualified nonphysician practitioner (NPP) whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The qualified NPP may perform consultation services within the scope of practice and licensure requirements for NPPs in the State in which he/she practices; • A request for an inpatient or emergency department telehealth consultation from an appropriate source and the need for an inpatient or emergency department telehealth consultation (i.e., the reason for a consultation service) shall be documented by the consultant in the patient's medical record and included in the requesting physician or qualified NPP's plan of care in the patient's medical record; and • After the inpatient or emergency department telehealth consultation is provided, the consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician. The intent of an inpatient or emergency department telehealth consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge. Unlike inpatient or emergency department telehealth consultations, the majority of subsequent inpatient hospital, emergency department and nursing facility care services require in-person visits to facilitate the comprehensive, coordinated, and personal care that medically volatile, acutely ill patients require on an ongoing basis. Subsequent hospital care services are limited to one telehealth visit every 3 days. Subsequent nursing facility care services are limited to one telehealth visit every 30 days. 190.3.2 - Telehealth Consultation Services, Emergency Department or Initial Inpatient Defined (Rev. 3817; Issued; 07-28-17 Effective; 01-01-18 Implementation: 01-02-18) Emergency department or initial inpatient telehealth consultations are furnished to beneficiaries in hospitals or SNFs via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the emergency department or initial inpatient consultation via telehealth cannot be the physician of record or the attending physician, and the emergency department or initial inpatient telehealth consultation would be distinct from the care provided by the physician of record or the attending physician. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. Emergency department or initial inpatient telehealth consultations are subject to the criteria for emergency department or initial inpatient telehealth consultation services, as described in section 190.3.1 of this chapter. Payment for emergency department or initial inpatient telehealth consultations includes all consultation related services furnished before, during, and after communicating with the patient via telehealth. Pre-service activities would include, but would not be limited to, reviewing patient data (for example, diagnostic and imaging studies, interim labwork) and communicating with other professionals or family members. Intra-service activities must include the three key elements described below for each procedure code. Post-service activities would include, but would not be limited to, completing medical records or other documentation and communicating results of the consultation and further care plans to other health care professionals. No additional E/M service could be billed for work related to an emergency department or initial inpatient telehealth consultation. Emergency department or initial inpatient telehealth consultations could be provided at various levels of complexity: • Practitioners taking a problem focused history, conducting a problem focused examination, and engaging in medical decision making that is straightforward, would bill HCPCS code G0425 (Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth). •

Practitioners taking a detailed history, conducting a detailed examination, and engaging in medical decision making that is of moderate complexity, would bill HCPCS code G0426 (Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth). • Practitioners taking a comprehensive history, conducting a comprehensive examination, and engaging in medical decision making that is of high complexity, would bill HCPCS code G0427 (Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth). Although emergency department or initial inpatient telehealth consultations are specific to telehealth, these services must be billed with POS 02 to identify the telehealth technology used to provide the service. 190.3.3 - Follow-Up Inpatient Telehealth Consultations Defined (Rev. 3817; Issued; 07-28-17 Effective; 01-01-18 Implementation: 01-02-18) Follow-up inpatient telehealth consultations are furnished to beneficiaries in hospitals or SNFs via telehealth to follow up on an initial consultation, or subsequent consultative visits requested by the attending physician. The initial inpatient consultation may have been provided in-person or via telehealth. Follow-up inpatient telehealth consultations include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status or no changes on the consulted health issue. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. The physician or practitioner who furnishes the inpatient follow-up consultation via telehealth cannot be the physician of record or the attending physician, and the follow-up inpatient consultation would be distinct from the follow-up care provided by the physician of record or the attending physician. If a physician consultant has initiated treatment at an initial consultation and participates thereafter in the patient's ongoing care management, such care would not be included in the definition of a follow-up inpatient consultation. Follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in section 190.3.1 of this chapter. Payment for follow-up inpatient telehealth consultations includes all consultation related services furnished before, during, and after communicating with the patient via telehealth. Pre-service activities would include, but would not be limited to, reviewing patient data (for example, diagnostic and imaging studies, interim labwork) and communicating with other professionals or family members. Intra-service activities must include at least two of the three key elements described below for each procedure code. Post-service activities would include, but would not be limited to, completing medical records or other documentation and communicating results of the consultation and further care plans to other health care professionals. No additional evaluation and management service could be billed for work related to a follow-up inpatient telehealth consultation. Follow-up inpatient telehealth consultations could be provided at various levels of complexity: • Practitioners taking a problem focused interval history, conducting a problem focused examination, and engaging in medical decision making that is straightforward or of low complexity, would bill a limited service, using HCPCS code G0406 (Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth). • Practitioners taking an expanded focused interval history, conducting an expanded problem focused examination, and engaging in medical decision making that is of moderate complexity, would bill an intermediate service using HCPCS code G0407(Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth). • Practitioners taking a detailed interval history, conducting a detailed examination, and engaging in medical decision making that is of high complexity, would bill a complex service, using HCPCS code G0408 (Follow-up inpatient telehealth consultation, complex, physicians typically spend 35

minutes or more communicating with the patient via telehealth). Although follow-up inpatient telehealth consultations are specific to telehealth, these services must be billed with POS 02 to identify the telehealth technology used to provide the service. 190.3.4 – Payment for ESRD-Related Services as a Telehealth Service (Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16) The ESRD-related services included in the monthly capitation payment (MCP) with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month may be paid as Medicare telehealth services. However, at least 1 visit must be furnished face-toface "hands on" to examine the vascular access site by a physician, clinical nurse specialist, nurse practitioner, or physician assistant. An interactive audio and video telecommunications system may be used for providing additional visits required under the 2-to-3 visit MCP and the 4-or-more visit MCP. The medical record must indicate that at least one of the visits was furnished face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner, or physician assistant. The MCP physician, for example, the physician or practitioner who is responsible for the complete monthly assessment of the patient and establishes the patient's plan of care, may use other physicians and practitioners to furnish ESRD-related visits through an interactive audio and video telecommunications system. The non-MCP physician or practitioner must have a relationship with the billing physician or practitioner such as a partner, employees of the same group practice or an employee of the MCP physician, for example, the non MCP physician or practitioner is either a W-2 employee or 1099 independent contractor. However, the physician or practitioner who is responsible for the complete monthly assessment and establishes the ESRD beneficiary's plan of care should bill for the MCP in any given month. Clinical Criteria The visit, including a clinical examination of the vascular access site, must be conducted face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner or physician's assistant. For additional visits, the physician or practitioner at the distant site is required, at a minimum, to use an interactive audio and video telecommunications system that allows the physician or practitioner to provide medical management services for a maintenance dialysis beneficiary. For example, an ESRD-related visit conducted via telecommunications system must permit the physician or practitioner at the distant site to perform an assessment of whether the dialysis is working effectively and whether the patient is tolerating the procedure well (physiologically and psychologically). During this assessment, the physician or practitioner at the distant site must be able to determine whether alteration in any aspect of the beneficiary's prescription is indicated, due to such changes as the estimate of the patient's dry weight. 190.3.5 – Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services (Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16) Subsequent hospital care services are limited to one telehealth visit every 3 days. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes. Similarly, subsequent nursing facility care services are limited to one telehealth visit every 30 days. Furthermore, subsequent nursing facility care services reported for a Federally-mandated periodic visit under 42 CFR 483.40(c) may not be furnished through telehealth. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes. Inpatient telehealth consultations are furnished to beneficiaries in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct

from the care provided by the physician or practitioner of record or the attending physician or practitioner. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. Initial and follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in section 190.3 of this chapter. 190.3.6 – Payment for Diabetes Self-Management Training (DSMT) as a Telehealth Service (Rev. 4173, Issued: 11-30-18, Effective: 01-01- 19, Implementation: 01-02-19) Individual and group DSMT services may be paid as a Medicare telehealth service. Before 03-11-2016, this manual provision required that 1 hour of the 10 hour DSMT benefit's initial training must be furnished in-person to allow for effective injection training. Because injection training is not always clinically indicated, we are revising this provision to permit all 10 hours of the initial training and the two (2) hours of annual follow-up training to be furnished via telehealth in those cases when injection training is not applicable. The in-person injection training, when provided, may be furnished through either individual or group DSMT services. By reporting place of service (POS) 02 or the – GT or –GQ modifier with HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes) or G0109 (Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes), the distant site practitioner attests that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training when it is indicated during the year following the initial DSMT service or any calendar year's 2 hours of follow-up training. As specified in 42 CFR 410.141(e) and stated in Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 300.2, individual and group DSMT services may be furnished by a physician, other individual, or entity that furnishes other items or services for which direct Medicare payment may be made and that submits necessary documentation to, and is accredited by a national accreditation organization approved by CMS. However, consistent with the statutory requirements of section 1834(m)(1) of the Act, as provided in 42 CFR 410.78(b)(1) and (b)(2) and stated in section 190.6 of this chapter, Medicare telehealth services, including individual and group DSMT services furnished as a telehealth service, could only be furnished by a physician, PA, NP, CNS, CNM , clinical psychologist, clinical social worker, or registered dietitian or nutrition professional, as applicable. 190.3.7 – Payment for Telehealth for Individuals with Acute Stroke (Rev. 4173, Issued: 11-30-18, Effective: 01-01- 19, Implementation: 01-02-19) Section 50325 of the Bipartisan Budget Act of 2018 amended section 1834(m) of the Act by adding a new paragraph (6) that provides special rules for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke (acute stroke telehealth services), as determined by the Secretary. Specifically, section 1834(m)(6)(A) of the Act removes the restrictions on the geographic locations and the types of originating sites where acute stroke telehealth services can be furnished. Section 1834(m)(6)(B) of the Act specifies that acute stroke telehealth services can be furnished in any hospital, critical access hospital, mobile stroke units (as defined by the Secretary), or any other site determined appropriate by the Secretary, in addition to the current eligible telehealth originating sites. Section 1834(m)(6)(C) of the Act limits payment of an originating site facility fee to acute stroke telehealth services furnished in sites that meet the usual telehealth restrictions under section 1834(m)(4)(C) of the Act. These are identified in Section 190.1 of this chapter. Effective for claims with dates of service on and after January 1, 2019, contractors shall accept new informat HCPCS modifier G0 (G zero), to be used to identify Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. Modifier G0 is valid for all: • Telehealth distant site codes billed with Place of Service (POS) code 02 or Critical Access Hospitals, CAH method II (revenue codes 096X, 097X, or 098X); or • Telehealth originating site facility fee, billed

with HCPCS code Q3014. 190.4 - Conditions of Payment (Rev. 1, 10-01-03) 1. 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. 2. 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. 3. "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. 4. 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. 190.5 - Originating Site Facility Fee Payment Methodology (Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16) 1. 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. 2. Facility fee for originating site The originating site facility fee is a separately billable Part B payment. The contractor pays it outside of other payment methodologies. This fee is subject to post payment verification. For telehealth services furnished from October 1, 2001, through December 31, 2002, the originating site facility fee was the lesser of $20 or the actual charge. For services furnished on or after January 1 of each subsequent year, the originating site facility fee is updated by the Medicare Economic Index. The updated fee is included in the Medicare Physician Fee Schedule (MPFS) Final Rule, which is published by November 1 prior to the start of the calendar year for which it is effective. The updated fee for each calendar year is also issued annually in a Recurring Update Notification instruction for January of each year. 3. Payment amount: The originating site facility fee is a separately billable Part B payment. The payment amount to the originating site is the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee, except CAHs. 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 OPPS. Payment is not based on the OPPS payment methodology. 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 separately from the cost-based reimbursement methodology. For CAH's, the payment amount is 80 percent of the originating site facility fee. 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 80 percent of the actual charge or 80 percent of the originating site facility fee, regardless of geographic location. The A/B MAC (B) shall 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 MPFS. Hospital-based or critical access-hospital based renal dialysis center (or their satellites). When a hospital-based or critical access hospital-based renal dialysis center (or their satellites) serves as the originating site, the originating site facility fee is covered in addition to any composite rate or MCP amount. Skilled nursing facility (SNF). The originating site facility fee is outside the SNF prospective payment system bundle and, as such, is not subject to SNF consolidated billing. The originating site facility fee is a separately billable Part B payment. Community Mental Health Center (CMHC). The originating site facility fee is not a partial hospitalization service. The originating site facility fee does not count towards the number of services used to determine payment for partial hospitalization services. The originating site facility fee is not bundled in the per diem payment for partial hospitalization. The originating site facility fee is a separately billable Part B payment. To receive the originating facility site fee, the provider submits 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." For A/B MAC (B) processed claims, the "office" place of service (code 11) is the only payable setting for code Q3014. There is no participation payment differential for code Q3014. Deductible and coinsurance rules apply to Q3014. By submitting Q3014 HCPCS code, the originating site authenticates they are located in either a rural HPSA or non-MSA county. This benefit may be billed on bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, and 85X. Unless otherwise applicable, report the originating site facility fee under revenue code 078X and include HCPCS code "Q3014, telehealth originating site facility fee." Hospitals and critical access hospitals bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in inpatient hospitals must be submitted on a 12X TOB using the date of discharge as the line item date of service. Independent and provider-based RHCs and FQHCs bill the appropriate A/B/MAC (A) using the RHC or FQHC bill type and billing number. HCPCS code Q3014 is the only non-RHC/FQHC service that is billed using the clinic/center bill type and provider number. All RHCs and FQHCs must use revenue code 078X when billing for the originating site facility fee. For all other non-RHC/FQHC services, provider based RHCs and FQHCs must bill using the base provider's bill type and billing number. Independent RHCs and FQHCs must bill the A/B MAC (B) 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 using revenue code 078X. Hospital-based or CAH-based renal dialysis centers (including satellites) bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in renal dialysis centers must be submitted on a 72X TOB. All hospital-based or CAH-based renal dialysis centers (including satellites) must use revenue code 078X when billing for the originating site facility fee. The renal dialysis

center serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary. Skilled nursing facilities (SNFs) bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in SNFs must be submitted on TOB 22X or 23X. For SNF inpatients in a covered Part A stay, the originating site facility fee must be submitted on a 22X TOB. All SNFs must use revenue code 078X when billing for the originating site facility fee. The SNF serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary. Community mental health centers (CMHCs) bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in CMHCs must be submitted on a 76X TOB. All CMHCs must use revenue code 078X when billing for the originating site facility fee. The CMHC serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary. Note that Q3014 does not count towards the number of services used to determine per diem payments for partial hospitalization services. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance. 190.6 - Payment Methodology for Physician/Practitioner at the Distant Site (Rev. 3586, Issued: 08-12-16, Effective: 01-01-17, Implementation: 01-03-17) 1. 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. 2. 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 at the facility rate. Payment for an office visit, consultation, individual psychotherapy or pharmacologic management via a telecommunications system should be made at the same facility 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. 3. 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. If the physician or practitioner at the distant site is located in a CAH that has elected Method II, and the physician or practitioner has reassigned his/her benefits to the CAH, the CAH bills its regular A/B/MAC (A) for the professional services provided at the distant site via a telecommunications system, in any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply. 4. 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* Registered dietitian or nutrition professional Certified registered nurse anesthetist *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. 190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners (Rev. 3817; Issued; 07-28-17 Effective; 01-01-18 Implementation: 01-02-18) Claims for telehealth services are submitted to the contractors that process claims for the performing physician/practitioner’s service area. Physicians/practitioners submit

the appropriate HCPCS procedure code for covered professional telehealth services with place of service code 02 (Telehealth). By billing place of service code 02 with a covered telehealth procedure code, the distant site physician/practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished. By billing the place of service code 02 with a covered ESRD-related service telehealth code, the distant site physician/practitioner certifies that 1 visit per month was furnished face-to-face "hands on" to examine the vascular access site. Refer to section 190.3.4 of this chapter for the conditions of telehealth payment for ESRD-related services. In situations where a CAH has elected payment Method II for CAH outpatients, and the practitioner has reassigned his/her benefits to the CAH, CAHs submit the appropriate HCPCS procedure code for the covered telehealth services with the GT modifier, and A/B/MACs (A) should make payment for telehealth services provided by the physician or practitioner at 80 percent of the MPFS facility amount for the distant site service. In all other cases, except for MNT services as discussed in Section 190.7- A/B MAC (B) Editing of Telehealth Claims, telehealth services provided by the physician or practitioner at the distant site are billed to the A/B/MAC (B). Physicians and practitioners at the distant site bill their A/B/MAC (B) for covered telehealth services. Physicians' and practitioners' offices serving as a telehealth originating site bill their A/B/MAC (B) for the originating site facility fee. 190.6.2 - Exception for Store and Forward (Noninteractive) Telehealth (Rev. 1, 10-01-03) In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, store and forward technologies may be used as a substitute for an interactive telecommunications system. Covered store and forward telehealth services are billed with the "GQ" modifier, "via asynchronous telecommunications system." By using the "GQ" modifier, the distant site physician/practitioner certifies that the asynchronous medical file was collected and transmitted to them at their distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii. 190.7 - A/B MAC (B) Editing of Telehealth Claims (Rev. 3817; Issued; 07-28-17 Effective; 01-01-18 Implementation: 01-02-18) Medicare telehealth services (as listed in section 190.3) are billed with POS 02. The contractor shall approve covered telehealth services if the physician or practitioner is licensed under State law to provide the service. Contractors must familiarize themselves with licensure provisions of States for which they process claims and disallow telehealth services furnished by physicians or practitioners who are not authorized to furnish the applicable 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. The contractor shall install edits to ensure that only properly licensed physicians and practitioners are paid for covered telehealth services. If a contractor receives claims for professional telehealth services coded with the "GQ" modifier (representing "via asynchronous telecommunications system"), it shall approve/pay for these services only if the physician or practitioner is affiliated with a Federal telemedicine demonstration conducted in Alaska or Hawaii. The contractor 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. Contractors shall deny telehealth services if the physician or practitioner is not eligible to bill for them. The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3. Group Code: CO CARC: 185 RARC: N/A MSN: 21.18 If a service is billed with POS 02 and the procedure code is not designated as a covered telehealth service, the contractor denies the service. The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying

claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3. Group Code: CO CARC: 96 RARC: N776 MSN: 9.4 The only claims from institutional facilities that FIs shall pay for telehealth services at the distant site, except for MNT services, are for physician or practitioner services when the distant site is located in a CAH that has elected Method II, and the physician or practitioner has reassigned his/her benefits to the CAH. The CAH bills its regular FI for the professional services provided at the distant site via a telecommunications system, in any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply. Claims from hospitals or CAHs for MNT services are submitted to the hospital's or CAH's regular FI. Payment is based on the non-facility amount on the Medicare Physician Fee Schedule for the particular HCPCS codes.