How to Get Reimbursed for Telehealth
How to Get Reimbursed for Telehealth

Getting reimbursed for telehealth services can be tricky. There's no doubt about that. The reimbursement guidelines vary greatly based on the payer, and are still constantly changing as more of the healthcare industry jumps on the telemedicine bandwagon.

To help guide you through billing and reimbursement, our eVisit team has done some research to answer the common questions we hear from providers. How do you bill for telemedicine? What do you need to know about state telemedicine policy? How does reimbursement differ for Medicare or Medicaid vs. private payers?

The bottom line is telehealth reimbursement can vary a lot depending on your state, practice, services, and the third-party payer. Here are some basic tips and guidelines to help you navigate reimbursement for your practice.

Tips for Telemedicine Reimbursement

The eVisit online and mobile app is an easy-to-use, secure, 2-way video platform that allows you to receive treatment from your doctor anytime, anywhere for common health issues.
1. **Determine The Type of Telehealth.**

There's a huge range of telehealth services available. Are you considering a live video solution? Software for remote patient monitoring? The type of telemedicine solution you're using will affect how you bill and how you get reimbursed. For instance, in all except two states, Medicare reimburses for live video telemedicine and not store-and-forward (also called asynchronous) solutions.

2. **Define Your Use Case.**

How will you be using telemedicine? Will you be using it to check-in with patients after hospital discharge? To treat patients with minor acute conditions like infections? To consult a specialist during a patient visit? Researching reimbursement will be easier if you have a specific use case in mind.

3. **Navigating Medicare.**

Here are a few things you need to know about Medicare and reimbursement for telemedicine services.

- **Defining Originating and Distant Site.**

  Defining the Originating and Distant Sites. Medicare reimburses for telehealth services offered by a healthcare provider at a Distant Site, to a Medicare beneficiary (the patient) at an Originating Site. The originating site must be in a HPSA (Health Professional Shortage Area). The types of originating sites authorized by law are:

  - Physicians or practitioner offices
  - Hospitals
  - Critical Access Hospitals (CAH)
  - Rural Health Clinics
  - Federally Qualified Health Centers
  - Hospital-based or CAH-based Renal Dialysis Centers
Skilled Nursing Facilities (SNF)
Community Mental Health Centers (CMHC)
Note: Independent Renal Dialysis Facilities are not eligible originating site

- The patient must be in a HPSA.

In order to be eligible for Medicare reimbursement, the patient (Medicare beneficiary) needs to be receiving virtual care at one of the clinical settings mentioned above, that is also located within a Health Professional Shortage Area (HPSA). To see if the health facility is in a HPSA, type in their address to this CMS tool.

- Only certain CPT and HCPCS codes are eligible for telemedicine reimbursement.

Medicare has a specific list of CPT and HCPCS codes that are covered under telemedicine services. You can use our printable list of the eligible CPT and HCPCS codes on page 9 as a quick cheatsheet (as of August 2015). Since that list is subject to change each year, we also recommend you check the CMS website.

- Use the GT modifier.

When billing for telemedicine visits, you need to include the "GT" modifier with the relevant CPT code to indicate the service was provided virtually.

- Billing a facility fee.

Medicare will also pay the originating site a facility fee, as reimbursement for hosting the telemedicine visit. For details on the facility fee, look up the HCPCS code Q3014.
Telemedicine reimbursement rates.

Medicare reimburses telemedicine services at the same rate as the comparable in-person medical service, based on the current Medicare physician fee schedule. Plus, the facility serving as the originating site can charge an additional facility fee.

Know where to find more information.

Check out this helpful PDF and resource list from the Medicare Learning network, if you have additional questions.


Each private payer does telemedicine reimbursement a little differently. The good news is, many of the large insurance companies are seeing the benefits of telemedicine and starting to provide broader coverage. Here are a few things you should know.

29 States and DC currently require private payers to reimburse telemedicine.

The list of states below (as of 9/2015) have enacted telemedicine parity laws, which require private payers to reimburse providers the same amount for telemedicine services as the comparable in-person service. To check for updates on state legislation, visit the ATA State policy center and review their helpful state legislation on matrix.
The big insurance carriers (BCBS, Aetna, Cigna, United Healthcare) cover telemedicine.

The largest commercial payers do cover telemedicine. However, whether they will reimburse for a telemedicine service is policy-dependent, meaning one patient might be covered under their BCBS policy and another may not if their policy excludes telemedicine.

Call your payers and ask the right questions.

The best way to find out telemedicine reimbursement policies from your private payers is to pick up the phone and call their eligibility and benefits department. Have a list of the relevant CPT codes on hand (see page 11). Here are a few questions to ask:

- Which CPT and HCPCS codes can be completed via telemedicine?
- Are there any restrictions on the location of the patient or provider?
- Do I need to use a modifier (GT)?
- Does the reimbursement rate match the in-person rate?
- Which providers are eligible (physician, NP, PA)?
- Are there any specific notes that need to be included in the visit documentation?

Verify the patient's insurance.

Since telemedicine is policy-dependent, you’ll need to verify that the patient’s insurance does cover it. Use the verification form on page 12 to call up the patient’s insurance carrier and record whether or not they’re covered.

5. Getting Paid through Medicaid.

With the constantly shifting state telemedicine policy landscape, you’ll need to do a little research to figure out how Medicaid reimbursement will work for your practice. Check out page 8 for a worksheet to help you research the telemedicine laws in your state.
How to Get Reimbursed for Telehealth

- **Lookup the Medicaid telemedicine reimbursement in your state.**

  Here are 3 great websites to help you research policy for your state:

  - The National Telehealth Policy Resource Center has an [interactive map of telehealth](#) policy, state-by-state.
  - Visit your [state Medicaid agency website](#).
  - Read [this policy analysis](#) from American Telemedicine Association.

- **What to research.**

  We have a printer-friendly worksheet on page 8, but here's a quick list of the factors you should be looking for, that could affect your telemedicine reimbursement through Medicaid.

  - Health Services covered
  - Eligible providers (NPs, Pas)
  - Is Cross-state licensing allowed?
  - Is a Pre-existing relationship with patient required?
  - Location restrictions on patient or provider
  - Applicable CPT codes
  - Type of fee reimbursed (transmission, facility, or both)

- **Connect with your local telehealth resource center.**

  The U.S. has 14 regional telehealth resource centers that are there to help you out. If you have questions about telemedicine reimbursement in your state, look up your local center and give them a call. Here's the [complete list of regional telehealth centers](#).
6. **Train your billing staff.**

Compile your research and share with your billing staff, and any providers using telemedicine. Billing staff will need to know the applicable codes and rules for each payer.

7. **Charge patients convenience fee.**

If all else fails, or you'd prefer not to spend the time researching reimbursement, you always have the option to charge the patient a convenience fee and forgo reimbursement from a third-party. This may not be ideal, but many patients seem not to mind paying a fee for the added convenience of a telemedicine service. Many of our clients at eVisit charge a convenience fee from $30 – 75 per visit.
### Medicaid & Telemedicine Reimbursement Worksheet

<table>
<thead>
<tr>
<th>State</th>
<th>__________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>__________________________</td>
</tr>
</tbody>
</table>

#### Type of telehealth
- Live, remote monitoring, store-and-forward

#### Eligible providers
- (MD, NPs, PAs, etc)

#### Cross-state licensing allowed?
- Are you allowed to do a telemedicine with a patient in another state?

#### Pre-existing relationship with patient required?

#### Prior authorization required?

#### Cross-state licensing allowed?
- Are you allowed to do a telemedicine with a patient in another state?

#### Eligible Health Services

#### Applicable CPT/HCPCS codes
- Note any codes applicable to your practice

#### Type of fee reimbursed
- (transmission, facility, or both)

#### Other Restrictions

#### Notes

#### Resources
- List any helpful websites here
### Medicare Telehealth Codes CY2015

<table>
<thead>
<tr>
<th>Service</th>
<th>Healthcare Common Procedure Coding System (HCPCS)/CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth consultations, emergency department or initial inpatient</td>
<td>HCPCS codes G0425–G0427</td>
</tr>
<tr>
<td>Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs</td>
<td>HCPCS codes G0406–G0408</td>
</tr>
<tr>
<td>Office or other outpatient visits</td>
<td>CPT codes 99201–99215</td>
</tr>
<tr>
<td>Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days</td>
<td>CPT codes 99231–99233</td>
</tr>
<tr>
<td>Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days</td>
<td>CPT codes 99307–99310</td>
</tr>
<tr>
<td>Individual and group kidney disease education services</td>
<td>HCPCS codes G0420 and G0421</td>
</tr>
<tr>
<td>Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training</td>
<td>HCPCS codes G0108 and G0109</td>
</tr>
<tr>
<td>Individual and group health and behavior assessment and intervention</td>
<td>CPT codes 96150–96154</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>CPT codes 90832–90834 and 90836–90838</td>
</tr>
<tr>
<td>Telehealth Pharmacologic Management</td>
<td>HCPCS code G0459</td>
</tr>
<tr>
<td>Psychiatric diagnostic interview examination</td>
<td>CPT codes 90791 and 90792</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment</td>
<td>CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961</td>
</tr>
<tr>
<td>Individual and group medical nutrition therapy</td>
<td>HCPCS code G0270 and CPT codes 97802–97804</td>
</tr>
<tr>
<td>Neurobehavioral status examination</td>
<td>CPT code 96116</td>
</tr>
<tr>
<td>Smoking cessation services</td>
<td>HCPCS codes G0436 and G0437 and CPT codes 99406</td>
</tr>
<tr>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services</td>
<td>HCPCS codes G0396 and G0397</td>
</tr>
<tr>
<td>Annual alcohol misuse screening, 15 minutes</td>
<td>HCPCS code G0442</td>
</tr>
<tr>
<td>Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td>
<td>HCPCS code G0443</td>
</tr>
<tr>
<td>Annual depression screening, 15 minutes</td>
<td>HCPCS code G0444</td>
</tr>
<tr>
<td>High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes</td>
<td>HCPCS code G0445</td>
</tr>
<tr>
<td>Service</td>
<td>Healthcare Common Procedure Coding System (HCPCS)/CPT Code</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes</td>
<td>HCPCS code G0446</td>
</tr>
<tr>
<td>Face-to-face behavioral counseling for obesity, 15 minutes</td>
<td>HCPCS code G0447</td>
</tr>
<tr>
<td>Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)</td>
<td>CPT code 99496</td>
</tr>
<tr>
<td>Psychoanalysis (effective for services furnished on and after January 1, 2015)</td>
<td>CPT codes 90845</td>
</tr>
<tr>
<td>Family psychotherapy (without the patient present) (effective for services furnished on and after January 1, 2015)</td>
<td>CPT code 90846</td>
</tr>
<tr>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present) (effective for services furnished on and after January 1, 2015)</td>
<td>CPT code 90847</td>
</tr>
<tr>
<td>Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (effective for services furnished on and after January 1, 2015)</td>
<td>CPT code 99354</td>
</tr>
<tr>
<td>Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (effective for services furnished on and after January 1, 2015)</td>
<td>CPT code 99355</td>
</tr>
<tr>
<td>Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit (effective for services furnished on and after January 1, 2015)</td>
<td>HCPCS code G0438</td>
</tr>
<tr>
<td>Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit (effective for services furnished on and after January 1, 2015)</td>
<td>HCPCS code G0439</td>
</tr>
</tbody>
</table>
Evaluative and Management Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>New Office Outpatient 10 Minutes</td>
</tr>
<tr>
<td>99202</td>
<td>New Office Outpatient 20 Minutes</td>
</tr>
<tr>
<td>99203</td>
<td>New Office Outpatient 30 Minutes</td>
</tr>
<tr>
<td>99204</td>
<td>New Office Outpatient 45 Minutes</td>
</tr>
<tr>
<td>99205</td>
<td>New Office Outpatient 60 Minutes</td>
</tr>
<tr>
<td>99211</td>
<td>Established Office Outpatient 5 Minutes</td>
</tr>
<tr>
<td>99212</td>
<td>Established Office Outpatient Visit 10 Minutes</td>
</tr>
<tr>
<td>99213</td>
<td>Established Office Outpatient Visit 15 Minutes</td>
</tr>
<tr>
<td>99214</td>
<td>Established Office Outpatient Visit 25 Minutes</td>
</tr>
<tr>
<td>99215</td>
<td>Established Office Outpatient Visit 40 Minutes</td>
</tr>
</tbody>
</table>

Telemedicine Specific Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99444</td>
<td>Online medical evaluation</td>
</tr>
</tbody>
</table>

* Note that in the case of Medicare, live video telemedicine visits should be billed using the appropriate E/M code along with the GT modifier to indicate telemedicine.

All the major commercial payers also recognize the GT modifier. However, commercial payer coverage of telemedicine is often policy-dependent and their rules for coding may vary. In some cases, they may prefer you use the telemedicine specific code. Call your private payers to verify the coding guidelines for telemedicine.
Insurance Verification Form

Date:_______________________________  Time:________________ a.m  p.m

Insurance:___________________________  Telephone #:________________________________

Rep Name and Reference Number :____________________________________________________

Patient First Name:____________________________  Last Name:__________________________

Member ID:_____________________________  DOB_______________________________

Plan Is:________________________________________

Effective Date:________________________________

Plan Pays:____________________ %  after deductible of:

Deductible?  Yes $_____________  Met $_____________

Family Ded?  Yes $_____________  Met $_____________

Out of Pocket Maximum:

Individual OOP? Yes $_____________  Met $_____________  Remaining $_____________

Family OOP?  Yes $_____________  Met $_____________  Remaining $_____________

Is Telemedicine covered?  Yes  No  If yes, requires authorization?  Yes  No

(specify code 99444)

Is the GT modifier recognized? Yes No  Is there a limit of Telemedicine visits?  Yes  No

Would an evaluation and management code be covered with a GT modifier?  Yes  No

Timely Filing OON__________  Elec Payer ID #_____________

Additional Notes:__________________________________________________________________
eVisit makes it easy for you to treat your patients anytime, anywhere. Our simple telehealth software platform lets you connect with patients via secure, high-resolution video chat - from your computer or mobile device.

With eVisit, providers have the tools they need to recapture patient visits from urgent care and the ER. Shorter visits, less no-shows, and anywhere access means physicians can optimize patient flow and boost practice revenue.

Patients get high-quality, convenient care from the doctor who knows them best. Providers improve their medical practices and patient care outcomes. Everyone wins.

Get a free demo now!

Call 844-693-8474
evisit.com