Reimbursement for telehealth is unfortunately complicated, and the policy environment is in constant flux. In addition to self-pay, Medicare, Medicaid and many private payers offer some form of reimbursement for telehealth delivered services. However, policies vary by both state and payer.

**THE BIG PICTURE**

The following factors may all play a role when determining whether a service can be reimbursed if delivered using telehealth technologies:

**Who is the third-party payer?**
- Medicare
- Medicaid
- Private Payer

**Who is the direct recipient of the telehealth encounter?**
- The patient
- Another clinician (E-Consult, Project ECHO)

**What modality of telehealth is being used?**
- Synchronous or “live” video
- Asynchronous or “store and forward”
- Remote monitoring
- Mobile health or “mHealth”

**Where is the patient located, otherwise known as the “originating site”?**
- Geographic Location
- Type of Facility
  - Health care facility (hospital, FQHC, private practice)
  - Non-health care facility (school, worksite, kiosk, home)

**What type of health care provider is delivering the service? (e.g., Medical Doctor, Nurse Practitioner, Psychologist, Allied Health Professional, Health Educator, EMT)**

**What type of service is being provided and how is that service being coded for billing purposes?**

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**MEDICAID AND PRIVATE PAYERS**

CMS gives states the ability to determine their own Medicaid policies related to telehealth which results in different policies across all 50 states and the District of Columbia. Policies may contain limitations such as the ones found in Medicare or additional requirements such as obtaining informed consent. Private payer policies may be dictated by state laws and also may vary greatly from payer to payer. While some private payer laws mandate coverage of services delivered via telehealth, they may not necessarily mandate that the reimbursement rate be equal to what it would be had the service been provided in person. Each Medicaid program and private payer law has its own caveats, requirements and restrictions associated with the various modalities of telehealth. Additionally, policies and laws change frequently. The Center for Connected Health Policy (CCHP) maintains a 50 State Telehealth Laws and Reimbursement database that is searchable by jurisdiction, rule type (laws, regulations, Medicaid Program) and topic. The database also tracks recent and pending legislative activity.

Visit [http://www.cchpca.org/](http://www.cchpca.org/) to get more detailed information about each state’s Medicaid policies and private payer laws.

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**MEDICARE**

Reimbursement for telehealth delivered services is only made if certain requirements are met. When billing, the 02 place of service (POS) code must be used to indicate the service took place via telehealth, except the GT modifier allowed on institutional claims by Critical Access Hospital Method II. The GQ modifier should be used for indicating a service took place via asynchronous/store-and-forward in a demonstration program in Alaska or Hawaii. To determine if a service qualifies for reimbursement under Medicare, the following must be met:

**Type of Service**

Medicare will only reimburse for a specific set of CPT/HCPCS code. Each year, Medicare may approve additional codes to be reimbursed. Medicare will only reimburse for live video. The only exception is when the service is provided by a federal demonstration project in Hawaii or Alaska, in which case, they will also reimburse for store-and-forward.
In order to be reimbursed for live-video telehealth, the patient must be located in a non-Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HPSA). The Health Resources Services Administration (HRSA) maintains a Medicare telehealth payment eligibility search tool (http://datawarehouse.hrsa.gov/tools/analyzers/geo/Telehealth.aspx) to determine if the specific location of an originating site qualifies. Additionally, Medicare limits the originating sites eligible to receive services through telehealth to the following facilities:

- Provider offices
- Critical access hospitals
- Federally qualified health centers
- Skilled nursing facilities
- Community mental health centers
- Hospitals
- Rural health clinics
- Hospital-based or critical access
- Hospital-based renal dialysis centers

In January 2019, CMS finalized regulations to reimburse for End-Stage Renal Disease (ESRD) services when delivered via telehealth to a patient's home or a renal dialysis facility and for acute stroke treatment when delivered via telehealth to a mobile stroke unit or any other eligible originating site. Additionally, CMS provides exemption from the geographic requirement to ESRD services delivered to the home, renal dialysis facilities, and hospital-based or critical access hospital-based renal dialysis centers. Mobile stroke units and all currently eligible originating sites are exempt from the geographic restrictions for acute stroke treatment services.

Beginning July 1, 2019, the originating site geographic requirements will be removed for any existing Medicare telehealth originating site for the purposes of treating individuals with substance use disorders or co-occurring mental health disorders. The home will be an eligible originating site for these services, however, it will not qualify for the facility fee.

Only the following list of distant site providers qualify to deliver services and receive reimbursement via telehealth through Medicare:

- Physicians
- Nurse practitioners
- Physician assistants
- Nurse midwives
- Clinical nurse specialists
- Clinical psychologists and clinical social workers
- Registered dietitians or nutrition professionals

CMS reimburses for chronic care management codes, which provides for non-face-to-face consultation and could include remote monitoring activities. Additionally, in the final calendar year 2018 Physician Fee Schedule, CMS unbundled code 99091 allowing providers to get reimbursed separately for time spent on collection and interpretation of health data generated remotely. Finally, in January 2019, CMS added reimbursement for 3 additional codes for remote physiological monitoring to align with new codes created by the CPT Editorial Panel.

In January, 2019, CMS began reimbursement for certain kinds of services furnished remotely using communications technology that are not considered “Medicare telehealth services.” Because these services are not defined as telehealth, they are not subject to the limitations and restrictions previously outlined for telehealth services.

Remote communication technology services include the following:

- Brief communication technology-based service (or “virtual check-in”): A brief, non-face-to-face check-in with an established patient via communication technology to assess whether or not an office visit or other service is necessary. This service is only available to practitioners who furnish E/M services, and could take place via live video or telephone call.

- Remote evaluation of pre-recorded patient information: Remote professional evaluation of patient-transmitted information conducted via pre-recorded video or image technology to determine whether or not an office visit or other service is necessary. This would only be available for established patients.

- Interprofessional internet consultation: Interprofessional internet consultations between professionals performed via communications technology. This service is limited to practitioners that can independently bill Medicare for E/M visits. This could take the form of either a telephone call or a live or synchronous internet consultation.

**NOTE:** Federally qualified health centers may provide both the Virtual Check-In and the Remote Evaluation of pre-recorded patient information. However, they are not able to use the interprofessional internet consultation codes.