



Medicare Reimbursement Checklist

Telehealth Professional Fees

January 2011

To bill Medicare for professional fees for telehealth encounters or consultations, **each box must be checked.**

- The patient was seen from one of the following “originating sites!”

<ul style="list-style-type: none"> • The office of a physician or practitioner • Hospital-based or critical access hospital-based renal dialysis center (including satellites) • Critical access hospital 	<ul style="list-style-type: none"> • Skilled nursing facility • Community mental health center • Hospital • Federally qualified health center • Rural health clinic
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- The encounter was performed by one of the following:

<ul style="list-style-type: none"> • Physician • Nurse Midwife • Clinical Psychologist • Registered Dietician or Nutrition Professional 	<ul style="list-style-type: none"> • Nurse Practitioner • Physician Assistant • Clinical Nurse Specialist • Clinical Social Worker
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- 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.
- Medicare beneficiary resides in, or utilizes the telemedicine system in federally designed rural Health Professional Shortage Area (HPSA), in a county that is not included in a Metropolitan Statistical Area (MSA); or 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.

The encounter involved one of the following CPT codes:

Telehealth Services:	CPT/HCPCS Codes	Telehealth Services:	CPT/HCPCS Codes
In-patient Consultations ²	G0425 - G0427	End Stage Renal Disease (ESRD) related services ³	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
Office or other out-patient visits	99201 - 99215	Neurobehavioral Status Exam	96116
Psychiatrist diagnostic interview examination	90801	Follow-up in-patient telehealth consultations ⁴	G0406, G0407, G0408
Individual psychotherapy	90804 - 90809	Health and Behavioral Assessment and Intervention Services (HBAI)	96150 - 69152
Individual Medical Nutrition Therapy	G0270, 97802, 97803	Group HBAI services (two or more patients)	96153
Group Medical Nutrition Therapy (MNT)	97804	Group HBAI services (family with the patient present)	96154
Individual Kidney Disease Education (KDE) services	G0420	Individual Diabetes Self-Management Training (DSMT) ⁵	G0108
Group Kidney Disease Education (KDE) services	G0421	Group Diabetes Self-Management Training (DSMT) ⁶	G0109
Pharmacologic management	90862	Subsequent hospital care services ⁷	99231, 99232, 99233
		Subsequent nursing facility care services ⁸	99307, 99308, 99309, 99310

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.

¹ As defined in legislation, an “originating site” is where the patient is located, and “distant site” is where the health care provider is located.

² 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.

³ 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.

⁴ 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.

⁵ 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.

⁶ 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.

⁷ Subsequent hospital care services, with the limitation for the patient’s admitting practitioner of one telehealth visit every three days.

⁸ Subsequent nursing facility care services, with the limitation for the patient’s admitting practitioner of one telehealth visit every 30 days.

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. This report was made possible by grant number G22RH20216 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.