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Medicare Reimbursement Checklist
Telehealth Originating Site Facility Fee
January 2011

In order for a defined eligible originating site to bill Medicare for a facility fee related to an eligible telehealth encounter, **each of the boxes must be checked.**

❑ The patient was seen from one of the following "originating sites[1]:"

• The office of a physician or practitioner • Hospital-based or critical access hospital-based renal dialysis center (including satellites) • Critical access hospital	• Skilled nursing facility • Community mental health center • Hospital • Federally qualified health center • rural health clinic

❑ The encounter was performed at the distant site by one of the following:

• Physician • Nurse Midwife • Clinical Psychologist • Registered Dietician or Nutrition Professional	• Nurse Practitioner • Physician Assistant • Clinical Nurse Specialist • Clinical Social Worker

❑ 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.

❑ The Medicare beneficiary resides in, or utilizes the telemedicine system in federally designated rural Health Professional Shortage Area (HPSA); in a county that is not included in a Metropolitan Statistical Area; 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*

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If **all** of the boxes are checked, you may submit a claim to Medicare and the following must occur:

- To receive the facility payment, submit claims with HCPCS code "Q3014 telehealth originating site facility fees:" Short description "telehealth facility fee." For CY 2011 the facility fee is 80 percent of the lesser of the actual charge or $24.10.
- The type of service for telehealth originating site facility fee is "9, other items and services."

IMPORTANT NOTE: There are various caveats to the originating site facility fee payments. Each billing department should receive the May 1, 2001 CMS Program Memorandum for the details in the section entitled Originating Site Facility Fee Payment Methology.

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[1] As defined in statute, 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.

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