



# Billing for Telehealth Encounters

## AN INTRODUCTORY GUIDE ON FEE-FOR-SERVICE

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## INTRODUCTION

Among the most frequent questions raised regarding telehealth is how an encounter is billed. According to the American Hospital Association, “76 percent of U.S. hospitals connect with patients and consulting practitioners at a distance through the use of video and other technology.”<sup>1</sup> It is not surprising then that the question of billing is the foremost question heard by telehealth resource centers, followed by, “will I get paid?” Further complicating the situation is that reimbursement policies vary from payer to payer. For example policies that apply to a Medicare beneficiary are different than those that apply to a Medicaid enrollee. Other common questions include: What are contracted rates with payers for in-clinic services and what are the state regulations? What are the plan terms? What, if any, financial obligations does the patient have? Plan terms may vary from plan-to-plan located in the same regions. How much you are paid depends on whom you bill for telehealth services and what services you provide.

Payment is not guaranteed for any type of visit, whether due to frequency limitations, diagnosis code or what the plan covers: is it an ambulatory clinic encounter, a surgery or an inpatient stay? Whatever the situation, this guide provides a starting point on how to bill a telehealth encounter for eligible practitioners in your practice or your facility. The focus of this guide will be primarily on fee-for-service Medicare and an example of one Medicaid program, California, highlighted in the blue Medical boxes. (For more detailed information on California billing, please visit the California Telehealth Resource Center’s website at [caltrc.org](http://caltrc.org).) Most of the descriptions and definitions are from the Centers for Medicare and Medicaid Services (CMS). Managed care plans, private payers and employer-based plans generally follow these rules though not every time, so always check with the plan. This resource is only provided as a guide and should not be considered legal advice.



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1) American Hospital Association, Fact Sheet: Telehealth, <https://www.aha.org/system/files/2019-02/fact-sheet-telehealth-2-4-19.pdf>.

## Billing for Synchronous and Asynchronous Telehealth

A consistent set of definitions for telehealth terminology has been hard to establish through the years. Definitions vary on the federal, state and individual payer level. For the purposes of this guide, we will use two examples, Medicare and California's Medicaid program, Medi-Cal, as starting points.

The following terms are provided to emphasize the key differences between the government programs, as this has implications on billing and what goes on the CMS 1500 or professional fee claim form and the UB-04 or facility fee claim form.

### ORIGINATING SITE

**MEDICARE:**<sup>2</sup> An originating site is the location where a Medicare beneficiary (the patient) connects with a physician or practitioner through telehealth. The beneficiary must go to the originating site for the services located in either:

- A county outside a Metropolitan Statistical Area (MSA) or
- A Rural Health Professional Shortage Area (HPSA) in a rural census tract.
- And be in a specific eligible site (*Figure 1*)

The Health Resources and Services Administration (HRSA) decides HPSAs, and the Census Bureau decides MSAs. To see a potential Medicare telehealth originating site's payment eligibility, go to HRSA's Medicare [Telehealth Payment Eligibility Analyzer](#).<sup>3</sup>

**MEDI-CAL:** "Originating site" means a site **where a patient is located** at the time health care services are provided via a telecommunications system or **where the asynchronous store and forward service originates**. For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the patient or by the health care provider is not limited (California Welfare and Institutions Code[CA W&I Code], Section 14132.72[e]). The type of setting may include, but is not limited to, a hospital, medical office, community clinic or the patient's home. [**Emphasis added.**]

Source: California Department of Health Care Services, Medi-Cal Provider Manual: Telehealth, page 2, August 2019.

### Figure 1 Medicare Originating Sites (Some allowable only for certain conditions)

- Physician and practitioner offices
- Hospitals
- Critical Access Hospitals (CAHs)
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs)
- Community Mental Health Centers (CMHCs)
- Renal Dialysis Facilities\*
- Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis\*
- Mobile Stroke Units\*
- Home of Patient receiving treatment for SUD/Opioid Abuse and co-occurring mental health disorders\*

\* Geographic limit may not apply to these facilities in specific circumstances.

NOTE: Geographic limitations on originating site removed for treatment & diagnosis of acute stroke.

2) Center for Medicare and Medicaid Services, MLN Booklet: Telehealth Services, January 2019. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsh.pdf>

3) Telehealth Payment Eligibility Analyzer, <https://data.hrsa.gov/tools/medicare/telehealth>.



## ORIGINATING SITE (cont)

As highlighted in Figure 1, there are now two instances where Medicare beneficiaries can receive treatment in the home:

- If they are undergoing Home Dialysis or
- As of July 1, 2019, “the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act” removes the originating site geographic conditions and adds an individual’s home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder.

Another important difference applies to asynchronous services. Medicare only allows asynchronous encounters to take place in a telehealth demonstration program in Alaska or Hawaii, whereas Medi-Cal does not have any geographic limitations. “Asynchronous store-and-forward” means the transmission of a patient’s medical information from an originating site to the health care provider at a distant site without the presence of the patient.”<sup>4</sup>

An originating site may bill Medicare a facility fee using code Q3014. If the originating site is the home, no facility fee may be billed.

## DISTANT SITE

Medicare does not provide a definition of where a distant provider site is, but does limit the type of provider who can provide a service, however, CMS has stated that providers cannot be located out of the country when providing the service via telehealth. Those providers include:



- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs) and clinical social workers (CSWs)<sup>5</sup>
- Registered dietitians or nutrition professionals



### Do you see the difference?

For **Medicare**, beneficiaries need to be at a site outside an MSA or within a defined eligible location, with a few exceptions. A **Medi-Cal** beneficiary can be geographically anywhere.

### Medi-Cal definition of Distant Site

Medi-Cal defines the “distant site” as “... a site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.” This allows the practitioner to be in a location suitable to telehealth encounters, but not necessarily in a clinic or facility themselves.

Source: California Department of Health Care Services, Medi-Cal Provider Manual: Telehealth, page 2, August 2019.

4) California Department of Health Care Services, Medi-Cal Provider Manual, Medicine: Telehealth, page 1, August 2019. <https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx>

5) CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.

## DISTANT SITE (cont)



### Are you in an RHC or FQHC?

Section 1834(m) (4) (C) (ii) of the Act authorizes RHCs and FQHCs to serve as telehealth “originating sites” (that is, where the patient is located) for qualified telehealth services in Medicare. FQHCs/RHCs may bill the Q3014 facility fee, however, Section 1834(m) (1) of the Act, which describes distant site telehealth services (where the practitioner is located), does not include RHCs and FQHCs. “We do not have the authority to allow RHCs and FQHCs to furnish distant site telehealth services, and RHCs and FQHCs may not bill for distant site telehealth services under the PFS.” – CMS, see the [Federal Register](#). This is Medicare’s policy. Medicaid policy varies from state-to-state.



### TRY IT!

Click on CCHP’s site, [here](#), to find your state. Compare your state’s policy definitions to Medicare’s: What is the same? What is different?

## PLACE OF SERVICE

CMS publishes a Place of Service (POS) code list, [here](#)<sup>6</sup>, so that a practitioner can “tell” the insurer via the billing form where the provider and patient were located during a health encounter. For synchronous telehealth services in Medicare, a POS 02 must go on the bill. The POS used when the services are not synchronous is where the service took place at the time of the encounter.

This also has implications on what address goes onto the bill. Prior to POS 02, the rule for selecting the POS for telehealth encounter was “where the beneficiary was at the time of the encounter.” Thus, the originating site was placed in Box 32. Now, however, based on a letter exchange between [CTeL](#) members and CMS regarding POS 02, CMS indicated that “... practitioners must use the address where they typically practice in Box 32. If they work part of the time out of a clinic and part of the time out of their home, they may use the clinic address. If they work out of their home 100% of the time, as some providers do, they must use their home address.” CTeL analysts indicated that “Medicare determines payment amounts based on a number of different factors that make up their Physician Fee Schedule formula. In short, part of the payment formula is based on the locality of the practitioner at the time of service—there are different rates for different localities. This is why Box 32 exists: to let CMS know which payment rate to slot into the formula for accurate reimbursement.”

Note that California’s Medicare Administrative Contractor (MAC), Noridian, recently held a webinar on Enrollment for Telehealth. According to Noridian, if the provider assigns their enrollment rights to a group or facility, then the group address is what is indicated on the CMS 1500, with the practitioner’s address known to CMS, but billed through the group entity.<sup>7</sup>

### Medi-Cal’s policy

**Medi-Cal’s policy is: “The distant site for purposes of telehealth can be different from the administrative location.” An interpretation of this statement, based on the above discussion, would indicate that the POS 02 address for Box 32 means – the practitioner’s “usual” place of business.**

6) Center for Medicare and Medicaid Services, Place of Service Code Set, [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set.html](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html). (Accessed November 8, 2019).

7) Noridian Health Care Solutions, Telehealth/Telemedicine Enrollment, <https://med.noridianmedicare.com/web/jeb/enrollment/complex-specialties/telehealth> (Accessed November 8, 2019).



## MODIFIERS AND REVENUE CODE

A modifier<sup>8</sup>, according to Noridian, based upon information provided by the AMA is as follows:

- Modifiers can be two digit numbers, two character modifiers, or alpha-numeric indicators. Modifiers provide additional information to payers to make sure your provider gets paid correctly for services rendered.
- If appropriate, more than one modifier may be used with a single procedure code; however, they are not applicable for every category of the CPT codes. Some modifiers can only be used with a particular category and some are not compatible with others.

For Medicare, a modifier is only required for the following:

- **G0** (zero): Used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.
- **GQ** (not used outside of Alaska or Hawaii): asynchronous telehealth service.
- **GT**: Critical Access Hospital distant site providers billing under CAH Optional Method II. This goes on an institutional claim and pays 80% of the Professional Fee Service rate.
- **GY**: Notice of Liability Not Issued, Not Required Under Payer Policy. Used to report that an Advanced Beneficiary Notice (ABN) was not issued because item or service is statutorily excluded or does not meet definition of any Medicare benefit.

Managed care and private plan policies on what modifier or POS to use vary. Always check with the plan to see what they require.

### Revenue Code 780

Revenue Code 780 is used for telemedicine institutional claims<sup>9</sup>. There is a lot of information concerning the CMS 1500 and professional fee services; however, there is minimal information about submitting institutional billing, except when referencing an FQHC or RHC. Examples will be provided below when this is appropriate to submit on a UB-04.

If you provide a telehealth visit to a Medicare beneficiary that did not meet the guidelines, append a GY modifier to your claim to indicate that you provided an excluded service



## For Medi-Cal, the modifiers for telehealth are as follows:



### Synchronous, Interactive Audio and Telecommunication Systems: Modifier 95

Modifier 95 must be used for Medi-Cal covered benefits or services delivered via synchronous, interactive audio/visual telecommunications systems. Only the portion(s) of the telehealth service rendered at the distant site are billed with modifier 95. The use of modifier 95 does not alter reimbursement for the CPT or HCPCS code.



### Asynchronous Store-and-Forward Telecommunication Systems: Modifier GQ

Modifier GQ must be used for Medi-Cal covered benefits or services including, but not limited to, teleophthalmology, teledermatology, teledentistry and teleradiology, delivered via asynchronous store-and-forward telecommunications systems, including through e-consult. Only the service(s) rendered from the distant site must be billed with modifier GQ.

The use of modifier GQ does not alter reimbursement for the CPT or HCPCS code billed.

Source: California Department of Health Care Services, Medi-Cal Provider Manual: Telehealth, pages 7-8, August 2019.

<sup>8</sup>) Noridian Health Care Solutions, Modifiers, <https://med.noridianmedicare.com/web/jeb/topics/modifiers> (Accessed November 8, 2019).

<sup>9</sup>) Noridian Healthcare Solutions, Revenue Codes, <https://med.noridianmedicare.com/web/jea/topics/claim-submission/revenue-codes>. (Accessed November 12, 2019).

## Billing for Virtual Healthcare

The following are a series of services that utilize telehealth technologies, but are not explicitly labeled “telehealth” by CMS. Not called “telehealth,” these services would not be limited by the restrictions in law placed on reimbursement for telehealth-delivered services in the Medicare program. They do not need a modifier or POS 02 – the POS on the CMS 1500 should reflect where the provider is located when performing the virtual care.

In the CY 2020 Physician Fee Schedule Final Rule, CMS responded to queries regarding obtaining consent for every instance of Virtual Healthcare and stated:



*[W]e are finalizing a policy to permit a single consent to be obtained for multiple CTBS [communication technology-based services] or interprofessional consultation services. Based on feedback from commenters, we believe an appropriate interval for the single consent is one year, and we are finalizing that the single consent must be obtained at least annually. We will continue to consider whether a separate consent should be obtained for services that involve direct interaction between the patient and practitioner, and those that do not involve interaction such as interprofessional services; and we may address this issue in potential future rulemaking.*



Medicare requires cost-sharing for all services and offered this response to comments requesting that cost-sharing be waived for these services:



*We also appreciate commenters’ continued concerns about the burden associated with cost sharing for CTBS and interprofessional consultation services. Although we do not have statutory authority to eliminate cost sharing for these services, we appreciate the continued input from the public as to how best to educate both practitioners and beneficiaries to reduce instances of unexpected bills.*



Before embarking on these services, consider the front-end education for your staff so that patients are provided with educational materials, as CMS suggests, so that the cost of the back-end, billing folks interacting with patients, do not negate the benefits of utilizing these services.

## REMOTE EVALUATION AND VIRTUAL CHECK-IN

In CY 2019, CMS finalized codes that will benefit from the annual consent policy, as above, and amplified education about cost-sharing. However, there are strict before and after time parameters to consider. These are:

**G2010** (Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store-and-forward), including interpretation with follow-up with the patient within 24 business hours, **not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available**)

And

**G2012** (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, **not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment**; 5-10 minutes of medical discussion)

[Emphasis added.]

Last year's Federal Register noted that the G2012 would also be a response to a patient-initiated communication, "[W]e expect that these services would be initiated by the patient, especially since many beneficiaries would be financially liable for sharing in the cost of these services."<sup>10</sup> One could surmise that the annual consent would potentially negate this expectation, since it is basing the expectation on having to inform the patient that this service will result in cost-sharing.

## REMOTE PHYSIOLOGIC MONITORING

Common Procedure Terminology (CPT) Code 99457 reads as



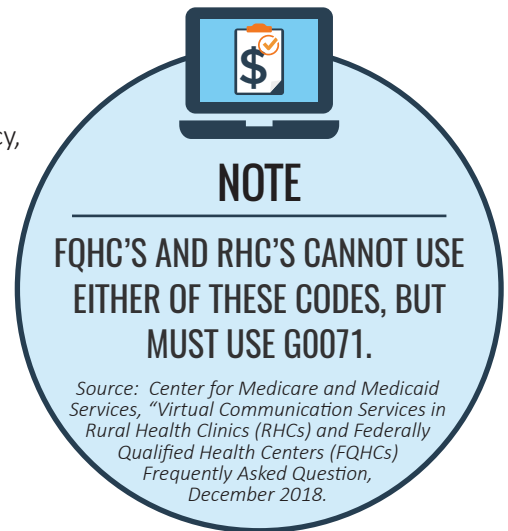
*"Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month."*



Remote Physiologic Monitoring is a subset of Special Care Management codes for patients who "require chronic, post-discharge or senior care. By connecting high-risk patients with remote monitoring, it can notify healthcare organizations of potential health issues or keep track of patient data between visits."<sup>11</sup>

10) Federal Register, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program." July 27, 2018. < <https://www.federalregister.gov/documents/2018/07/27/2018-14985/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions#p-256> > (Accessed November 12, 2019).

11) Tech Target, Mobile: Healthcare IT, remote patient monitoring (RPM). April 2019. <https://searchhealthit.techtarget.com/definition/remote-patient-monitoring-RPM> (Accessed November 12, 2019).





## REMOTE PHYSIOLOGIC MONITORING (cont)

Note that Remote Physiological Monitoring can be done under general supervision and billed under the NPI-holding practitioner. You must follow the incident-to rules for different types of practices (see box comment).

There are two additional codes to bill staff activities. Depending on your type of clinic, the codes will go out on a CMS 1500 or on the UB-04 if you are mindful of the incident-to rules. The codes have time requirements, as well:

- **99453:** device initial set-up code which can be billed after 16 days of monitoring; and
- **99454:** the transmission code that should be billed at the end of each 30-day monitoring period or after monitoring has ended (if less than 30 days) based on CMS guidance on other remote monitoring services.



### REMEMBER

Monitoring must last at least 16 days to be billed.

- According to an MLN issued in February 2019 (SE 17023)<sup>12</sup>, 30-day remote cardiac monitoring services can be billed after monitoring is completed.
- Providers should bill at the end of each 30-day monitoring period or, if monitoring lasts less than 30 days, when monitoring ends.

Finally, if you are a provider who can independently bill, CPT 99091, collection and interpretation of physiologic data, may be used to virtually report medical guidance to a patient via the EMR or other secure method.



### Incident-to:

Can be done when there is a direct contractual relationship between the provider and staff. If the medical group and facility employees are owned or managed by two different entities, you may not utilize incident-to services.



### Do not bill Remote Physiologic Monitoring at the following sites:

FQHCs  
RHCs  
Home Health Agencies

*(All can claim as an expense)*

## eCONSULT OR INTERPROFESSIONAL CONSULTATIONS

Medicare opted to initiate payment for Interprofessional Consultations or eConsults in 2019. It does not consider an eConsult to be a “telehealth” service, but rather part of what it is calling “Special Care Management” codes.<sup>13</sup> FQHCs and RHCs cannot bill for eConsult under Medicare. The definitions offered by CMS are:

**99446-99449:** “Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a **verbal** and written report to the patient’s treating/requesting physician or other qualified health care professional (5 minutes through and over 31 minutes).” [Emphasis added.]

12) Center for Medicare and Medicaid Services, Guidance on Coding and Billing Date of Service on Professional Claims, February 2019. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17023.pdf>. (Accessed November 8, 2019).

13) Federal Register, Proposed Physician Fee Schedule CY 2020, Table 16, <https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-16041.pdf>. (Accessed November 8, 2019).

## ECONSULT OR INTERPROFESSIONAL CONSULTATIONS (cont)

**99451:** Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.

**99452:** Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes.

## ONLINE DIGITAL EVALUATION SERVICE (eVISIT)

The following codes were finalized for CY 2020. The following excerpt from the Federal Register<sup>14</sup> describes the use and payment for non-National Provider Identifier (NPI)<sup>15</sup> practitioner reimbursement (clinical staff can be pharmacists, medical assistants, technicians, nurses, therapists, according to Noridian).<sup>16</sup>

The Online Digital Evaluation Service (e-Visit) CPT codes and descriptors are as follows:

**98970** (Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes);

**98971** (Qualified nonphysician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes); and

**98972** (Qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes).

"99421-99423 are for practitioners who can independently bill E/M services while CPT codes 98970-98972 are for practitioners who cannot independently bill E/M services."

Medicaid programs may adopt these codes, but you will need to check with on your State's Medicaid program to determine the status.



## Medi-Cal considers eConsults to be telehealth and requires the use of the GQ modifier to indicate that asynchronous treatment was rendered.

### Medi-Cal also states in its policy:

*Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.*

In accordance with the AMA requirements, CPT code 99451 is not separately reportable or reimbursable if any of the following are true:

- The distant site provider (consultant) saw the patient within the last 14 days.
- The e-consult results in a transfer of care or other face-to-face service with the distant site provider (consultant) within the next 14 days or next available appointment date of the consultant.
- The distant site provider did not spend at least five minutes of medical consultative time, and it did not result in a written report.

*Source: California Department of Health Care Services, Medi-Cal Provider Manual: Telehealth, page 9, August 2019.*

14) Federal Register, Final Physician Fee Schedule CY 2020, , page 799, <https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-16041.pdf>. (Accessed November 8, 2019).

15) Look up NPI or National Provider Identifier at <https://npiregistry.cms.hhs.gov/>.

16) <https://med.noridianmedicare.com/web/jeb/specialties/em/chronic-care-management-ccm#pelegibility>

## mHEALTH

The American Medical Association (AMA) defines mHealth as “using mobile-based solutions to deliver health services. Examples of mHealth include an app for a smartphone that allows users to assess their risk for cardiovascular disease and then identifies nearby screening locations to schedule an appointment as well as sensors that can measure blood pressure, pulse, glucose and other physiologic parameters.”<sup>17</sup>

## Other Considerations

### PRACTICE TYPE

Can you describe your place of work in two numbers? If so, you must be a coder/biller. If not or if you are asked to bill for a different type of facility, a succinct listing of practice types is provided by CMS on its website.<sup>18</sup> There are descriptions that describe the practice and what code to put on the bill.

The following describes a few of the settings that people regularly ask about in terms of billing.

**Independent Clinic (POS 49):** a clinic that is not part of a hospital and is for outpatient treatment. The employees in this type of practice will be able to act under general or direct supervision of the treating practitioner who is managing patient care. This means incident-to billing can occur, which has an impact on the RPM codes, above. This also affects whether or not certain Chronic Care Management (CCM)<sup>19</sup> services can be billed.

This can be an originating site for Medicare services if eligible under HRSA guidelines, as well as a distant site. Note that Remote Physiological Monitoring and CCM do not fall under geographic restrictions, as they are not “telehealth.”

**Off Campus Outpatient Hospital Clinic (POS 19):** this type of clinic employs staff who do not have a direct employment relationship with the ordering physicians. Thus, any activities performed under the direct or general supervision of the physician are bundled with the facility services on the UB-04 and cannot be reported on the CMS 1500 or billed under the physician’s NPI.<sup>20</sup>



### CONSIDERATIONS

The type of practice you work in – or where your practitioners provide services – dictates what can be billed, how the service is billed and whether or not incident-to billing can be utilized.



### Privileging, credentialing and enrollment assignment:

Have your providers contracted to see patients at originating sites? Where will you document? Who will do the billing?



### PRO FEE AND HOSPITAL FEE

Can your practice bill incident-to services? Do you employ the RNs and other clinical staff? Do you work at an off-campus (physician based) facility outpatient clinic?

Part B outpatient services for Professional fees are submitted on the CMS 1500 and the Part A or Facility Fee portion is submitted on the UB-04.

17) American Medical Association, “How the definitions of digital health differ,” February 5, 2015. <https://www.ama-assn.org/practice-management/digital/how-definitions-digital-health-differ>. (Accessed November 8, 2019).

18) Center for Medicare and Medicaid Services, Place of Service Code Set, [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set.html](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html). (Accessed November 8, 2019).

19) Center for Medicare and Medicaid Services, Health Care Professional Resources, <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/ccm/hcpresources.html>. (Accessed November 8, 2019).

20) Center for Medicare and Medicaid Services, Medicare Learning Network, MLN Matters: SE0441, August, 23, 2016. <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se0441.pdf>

## PRACTICE TYPE (cont)

*A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016.)<sup>21</sup>*

Again, this can be an originating site for Medicare services if eligible under requirements, as well as a distant site.

**Inpatient service (POS 21):** This can be an originating site for Medicare services if eligible under requirements, as well as a distant site. Refer to the List of Telehealth Services for Healthcare Common Procedure Coding System (HCPCS) codes applicable to Medicare-only billing. The usual inpatient codes apply to Medi-Cal and other payers for reimbursement.

**Emergency Room – Hospital (POS 23):** This is a great place to use the modifier applicable to stroke intervention – G0 (zero) – for remote neurologists, as geographic restrictions do not apply for Medicare beneficiaries. Other services are billable with the geographic limitation caveat and there are specific HCPCS codes applicable to the ER setting. You can find these codes on the Medicare Telehealth List that can be downloaded with the Physician Fee Schedule related materials.

**On-Campus, Facility-Based Hospital Clinic (POS 22):** A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization can serve as an originating site, as well as a distant site. As with the other identified sites, services will be billed out using POS 02. (Description change effective January 1, 2016.)<sup>22</sup>

**Federally Qualified Health Clinic (FQHC)<sup>23</sup> (POS 50):** Authorized to serve as an originating site for telehealth services if the FQHC is located in a qualifying area. An originating site is the location of an eligible Medicare patient at the time the service being furnished via a telecommunications system occurs. FQHCs that serve as an originating site for telehealth services are paid an originating site facility fee. FQHCs are not authorized to serve as a distant site for telehealth consultations in Medicare. Policies in Medicaid vary from state-to-state. A distant site is the location of the practitioner at the time the telehealth service is furnished. The cost of a visit may not be billed or included on the cost report.

**Rural Health Clinic (POS 72):** A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician. May serve as an originating site in Medicare. Policies in Medicaid vary from state-to-state.

HRSA created a publication "Starting a Rural Health Clinic- A How-To Manual."<sup>24</sup> It states "There are two types of RHCs: provider-based and independent. Provider-based clinics are those clinics owned and operated as an "integral part" of a hospital, nursing home or home health agency. Independent RHCs are those facilities owned by an entity other than a "provider" or a clinic owned by a provider that fails to meet the "integral part" criteria." While considering incident-to, one may think that a provider-based clinic would allow for this billing; however, according to the manual it does not. All facility services are considered bundled.

21) Center for Medicare and Medicaid Services, Pub 100-04 Medicare Claims Processing, August 6, 2015. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3315CP.pdf>

22) Ibid.

23) Center for Medicare and Medicaid Services, Medicare Learning Network, Federally Qualified Health Center, January 2018, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf>

24) US Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, "Starting a Rural Health Clinic – A How To Manual."



### Registered dietitians, Physical therapists, Genetic counselors:

Little guidance exists on how to bill these services in facilities. Since telehealth services are a modality, bill as you would normally. Use Revenue Code 780 on your UB-04.



## PRACTICE TYPE (cont)

**Indian Health Services:** there are multiple places of service that fall under the jurisdiction of Indian Health:

- Facts:
  - ✓ Funding: Federally funded.
  - ✓ Location: Both on and off of surrounding reservations.
  - ✓ Customer: Federally recognized Tribal Members from surrounding areas.
- Tribal 638 Agmt Free-standing Facility (POS 07).
- Tribal 638 Agmt Provider-based Facility (POS 08).
  - ✓ Funding: The Tribe self-administers the funding and Health Services.
  - ✓ Location: Tribal Reservations (Federal Trust Land).
  - ✓ Customer: Tribal Members only.

The IHS maintains a Telehealth Behavioral Health Center of Excellence (TBHCE)<sup>25</sup> and acts as a “hub” to health sites all over the country. The TBHCE contracts its services to the sites and the sites then can bill Medicare and Medicaid for those services. Other specialty services include Rheumatology, Endocrinology, Psychiatry, Infectious Disease and the aforementioned Behavioral Health. All services are based at the clinics.

## THINGS TO KEEP IN MIND

There are other policies to consider that could impact your telehealth billing as well as opportunities that may not be readily apparent because services are not called “telehealth” but utilize the technology. The following are a few things to keep in mind.

### Accountable Care Organizations (primarily High Risk Bearing ACOs)

In January 2020, waivers to originating site limitations can be applied to Next Generation ACOs. The geographic and location restrictions will be lifted and home health workers will be able to check in on their patients remotely.<sup>26</sup>

### Patient demographics

Patient demographics are going to affect your billing workflows and choices. If located in a pediatric clinic, the focus will be on private payer policies and Medicaid. Think about where your patients are located and if your providers want to contract with FQHCs to better serve sites that lack specialty care.

### Payer Mix and Billing Rules

In sharing definitions, places of service and other considerations such as demographics, note the following:

**Medicare Fee-for-Service:** its rules are found in the Telehealth Guidelines previously referenced.

**Medicare Advantage:** Beginning in January 2020, Advantage plans will be allowed to offer more extensive telehealth coverage as part of “base coverage” as they do for other excluded services, such as eyeglasses after cataract surgery. Telehealth policies will vary from plan to plan.



**Medi-Cal:** DHCS finalized its policy in July 2019 and is aligned with the state regulatory language in terms of originating site, coverage and reimbursement.

**CCS-GHPP:** CCS/GHPP was first in offering coverage for physical and occupational therapies, as well as other coverage for its patients.

**Covered California:** this group of payers available through the California Marketplace Exchange must offer basic coverages as mandated by the Affordable Care Act. In Calendar Year 2020, it is up to the insurance payers in the Exchange to determine whether telehealth will be covered as a “base.”

25) Indian Health Services, Telebehavioral Health Center of Excellence, <https://www.ihs.gov/telebehavioral/>. (Accessed November 8, 2019).

26) Center for Medicare and Medicaid Services, “Telehealth Expansion Benefit,” <https://innovation.cms.gov/Files/x/nextgenaco-whatistelehealthwaiver.pdf>.

## THINGS TO KEEP IN MIND (cont)

**Commercial:** Be aware of the contracts in place for your place of work. Be cognizant that the state parity law may provide coverage security as well as advising that if a similarly covered “in-person” service at a clinic or hospital is conducted via telehealth that it should be paid in kind.

### Other Potential Billing Opportunities in Care Management

There are other ways to benefit from the use of telehealth components in bundled management of care scenarios: chronic care management<sup>27</sup> (CCM) and transitional care management<sup>28</sup> (TCM). These two programs can be billed during the same period, as they fill two distinctly different needs. This changed with the PFS 2020 Final Rule. Unlike the services set out above, FQHCs<sup>29</sup> and RHCs<sup>30</sup> can benefit from these programs. Note that as of January 1, 2019, “CCM services can be billed [by FQHC and RHC] by adding the general care management G code, G0511.”<sup>31</sup> In addition, codes for “Principal Care Management (PCM)” were released for calendar year 2020. G2064 and G2065 are intended to address the care of single diagnosis chronic care situations, post-hospitalization or episode of onset, for short periods of time (3 months).<sup>32</sup>

For **CCM and Complex CCM** (see below), a patient has two or more chronic conditions monitored by a practitioner and staff. Depending on the type of clinic, these codes may be billed if the requirements are met: a plan is established, put into use, changed if needed and monitored. Note that CCM and Complex CCM may be under “general supervision,” but remember to follow the incident-to rules.

**CPT 99490:** 20 minutes or more per month of directed staff time for two or more chronic conditions expected to last during a 12 month period or until death. This also assumes 15 minutes of the billing practitioner’s time per month as well.

**CPT 99491:** 30 minutes or more of a “qualified health care professional” only (in layperson’s terms, a billing provider who has an NPI), per month.

**CPT 99487:** “Complex” CCM, which is 60 minutes of clinical staff time as directed by a billing practitioner with the above-required elements of 99490.

**CPT 99489:** this is an add-on code, meaning you cannot bill it without 99487. It is for 30 minutes of time in addition to the 60 minutes of recorded time billed for a 99487.



## You may have heard about the recent passage of AB744 in California.

The law will go into effect in January 2021 and will require payment parity for telehealth services provided elsewhere (for example in a clinic). For details, you may read the final law [here](#).



### Eligibility

Could be based on number of illnesses, number of meds or repeat admits or trips to the ED – check your CPT book preamble for more scenarios

27) Center for Medicare and Medicaid Services, Details for title 2019-07. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909188.html>. (Accessed November 8, 2019).

28) Ibid.

29) Noridian Health Care Solutions, Federally Qualified Health Centers (FQHC) Billing Guide. <https://med.noridianmedicare.com/web/jea/provider-types/fqhc/fqhc-billing-guide>. (Accessed November 8, 2019).

30) Noridian Health Care Solutions, RHC Billing Guide, <https://med.noridianmedicare.com/web/jea/provider-types/rhc/rhc-billing-guide>. (Accessed November 8, 2019).

31) Center for Medicare and Medicaid Services, “Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), Frequently Asked Questions, December 2018.” <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf> (Accessed November 8, 2019).

32) Final Rule to CY 2020 Physician Fee Schedule. <https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf>. (Accessed November 12, 2019).

## THINGS TO KEEP IN MIND (cont)

Because of the 24/7 access to care requirement of CCM, a provider can use various modalities to stay in touch such as “telephone, secure messaging, secure Internet or other asynchronous non face-to-face consultation methods (for example, email or secure electronic patient portal.)”

**TCM** is to manage post inpatient admission discharge patients to ensure continuity of care within a 30-day period (the first day is date of discharge + 29 days). It can be performed by the discharging service or the PCP who is accepting care of the patient back into their community. There are two types of medical decisions involved, as well:

- Moderate/99495: within 2 days, modality (telephone, electronic) or direct contact. A follow-up visit must occur face-to-face within **14 calendar days of discharge**.
- High/99496: within 2 days, modality (telephone, electronic) or direct contact. A follow-up visit must occur face-to-face within **7 calendar days of discharge**.

For the in-person or face-to-face encounter conducted via telehealth, if this is a CMS beneficiary, the telehealth geographic limitations are in effect. However, this can stand in for the “face-to-face” or in-person encounter, which is a great benefit to the beneficiary. TCM codes can now be billed during the same time period as CCM codes.

### Preparation

Each year, in July, CMS releases the proposed Physician Fee Schedule (PFS) for the following calendar year. The proposed fee schedule, as well as the finalized fee schedule is published on the same web page, entitled “PFS Federal Regulation Notices.”<sup>33</sup> The proposed rule is indicated by a number ending in “P”; final in “F” and correction notes as “CN.” The finalized schedules are released in November. For CY 2019, the number is CMS 1693-F. Clicking on the link takes you to the “Details Page.”

The downloads contain Excel spreadsheets with different numbers, but the two Zip files we need are the first one “Final Rule Addenda” and “Final Rule List of Telehealth Services.”

**Step 1:** Download “Addendum B – Relative Value Units and Related Information Used in CY 20XX Final Rule”. This list will provide details on whether or not the non-telehealth codes are “A” active or not and the second spreadsheet lists all the current, active telehealth services. Save the spreadsheets in a convenient place on your computer.

**Step 2:** Then Download “CMS-XXXX-F List of Medicare Telehealth Services.”

**Step 3:** Next, go to your state’s Medicaid website or if you are coding multi-state encounters, you can easily find each state’s policies on the CCHP’s 50 state review webpage.<sup>34</sup> If there are specific CPT codes covered in those states, add them to your Telehealth spreadsheet and start to keep track of what you are billing, who is paying and who is denying and for what reasons the denials are applied.

This is all-important information to manage as your program grows.



**Are you the surgeon or provider who performed a procedure on the TCM patient?**

**Then you cannot bill within the global period of the procedure.**

**Are you the primary care physician or hospitalist who discharged the TCM patient?**

**Then you can bill within a global period, within the 30 days of discharge.**

33) Center for Medicare and Medicaid Services, PFS Federal Regulation Notice. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index>. (Accessed November 8, 2019).

34) Center for Connected Health Policy, 50 State Current State Laws and Medicaid Policies, <https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies>. (Accessed November 8, 2019).

## EXAMPLES



**PATIENT 1:** The practitioner documented a synchronous telehealth visit, with an established, follow-up patient, aged 65, for a level 3 problem (99213), with a diagnosis XX. *Insurance: Medicare*

### CODE IT:<sup>35</sup>

- Check the CMS Telehealth Services List. (CPT codes are listed in the first column, headed "Code.") 99213 is there, so CMS will pay 100% of the PAR fee. No Modifier needed, because POS is 02.

LIST OF MEDICARE TELEHEALTH SERVICES	
CY 2019	
Code	Short Descriptor
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est

1	QUALIFIER + NDC OR UPN			UNIT QUALIFIER AND QUANTITY		
	DOS FROM	DOS THRU	POS	PROC CODE	MODIFIERS	
2	01 01 19	01 01 19	02	99213		
3						
4						
5						

- Check the patient's originating site clinic address on the [HRSA](#) site: Yes! The originating site qualifies for reimbursement.

✓ Yes

Yes, the geocoded address is eligible for Medicare telehealth payment.

Put the address of the distant site provider (your provider) in Box 32:

FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO. <b>PATIENT ACCOUNT NUMBER</b>	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO
SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION <b>NAME AND ADDRESS OF SERVICE FACILITY</b>	
SIGNATURE OF PROVIDER			

35) You may refer to the List of Medicare Telehealth Services or the AMA's CPT book Appendix P for the list of covered telehealth codes.





**PATIENT 1 (cont):** The practitioner documented a synchronous telehealth visit, with an established, follow-up patient, aged 65, for a level 3 problem (99213), with a diagnosis XX. *Insurance: Medicare*

## CODE IT (cont):

What about the facility's charge? For non-telehealth visits, the G0463 is billed for all outpatient evaluation and management visits. For telehealth, however, CMS does not pay for a distant site facility.

However, the originating site facility can bill the Q3014 (originating site facility fee) and that can be submitted on the CMS 1500.

Finally, what if the Medicare beneficiary's originating site address does not meet HRSA's guidelines? Then you bill the same, except with a GY modifier:

MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HQPCS	MODIFIER	PC
QUALIFIER + NDC OR UPN						UNIT QUALIFIER AND QUANTITY				
DOS FROM		DOS THRU		POS	DELAY EMER	PROC CODE	MODIFIERS			
01 01 19		01 01 19		02		99213	GY			

The GY tells the Medicare Administrative Carrier (MAC) that the service was statutorily excluded and to not pay the practitioner.



**PATIENT 2:** Synchronous telehealth visit, follow-up patient, aged 25, documented 99213, analysis and interpretation of Continuous Glucose Monitoring (CGM) data (95251), diagnosis XX. *Insurance: Medi-Cal*

## CODE IT:

Since this is Medi-Cal, its policy states that any medically necessary service that is feasible via telehealth is reimbursed, so there is no need to check any CPT Code list. Moreover, the CGM is separately reimbursable, so the E/M code requires a modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service)<sup>36</sup>.

In addition, Medi-Cal requires a 95 modifier, so your CMS 1500 would look like this:

95251 is not a telehealth service and does not require modifier 95. However, the analysis and interpretation took place in the office, so POS 22 goes onto the same claim but as a separate line item.

1	QUALIFIER + NDC OR UPN						UNIT QUALIFIER AND QUANTITY				
	DOS FROM		DOS THRU		POS	DELAY EMER	PROC CODE	MODIFIERS			
2	01 01 19		01 01 19		02		99213	95 25			
3	01 01 19		01 01 19		22		95251				

36) The Medi-Cal modifier list is a Word document, located [here](#)



**PATIENT 3:** 65-year-old patient meets with staff of an independent clinic to be fitted for/educated about a remote monitoring device on the 15th of the month and undergoes monitoring that lasts through the 16th of the next month (30 days). The physician interprets the data and communicates to the patient about changing her regimen. *Insurance: Medicare or Medi-Cal.*

## CODE IT:

The codes for remote monitoring were outlined, above. As a private practice, POS 11 is used. This is not telehealth, according to Medicare, so POS 02 is not applicable in this situation.

1	QUALIFIER + NDC OR UPN				UNIT QUALIF
	DOS FROM	DOS THRU	POS	DELAY EMER	PROC CODE
2	01 15 19	02 17 19	11		99453
3	01 15 19	02 17 19	11		95454
4	02 17 19	02 17 19	11		99457
5					

Your next question may be “what device qualifies for remote monitoring?” According to the FDA:

1. The device “must be a medical device as defined by the FDA”; and
2. The service must be ordered by a physician or other qualified health care professional.

The FDA outlines its medical device guidelines, [here](#), depending on the context of how and what you are monitoring. This is not clear. Here are a few examples, as outlined in a recent article<sup>37</sup>:

- Glucose meters for patients with diabetes.
- Heart rate or blood pressure monitors.
- Continuous surveillance monitors that can locate patients with conditions like dementia and alert healthcare professionals of an event like a fall.
- Remote infertility treatment and monitoring.
- At-home tests that can keep substance abuse patients accountable for and on track with their goals.
- Caloric intake or diet logging programs.

We put the phrase “or Medi-Cal” in the above Patient’s Insurance information because Medi-Cal does not cover remote monitoring, but they may cover specific codes that have remote monitoring features. For example, as of August 2019, in the Medi-Cal Procedure Inquiry Response portal, code 99457 is listed at \$44.84; but it goes on to state that “This procedure is not a covered benefit. No TAR or medi-reservation required.” Therefore, the code is in the Medi-Cal system, but not reimbursed at this time. It would be a good idea to check back periodically on the Transaction Portal as sometimes updates are made with little fanfare.

37) TechTarget SearchHealthIT: <https://www.caregivingmetrowest.org/Caregiver-Toolkit/Blog-Caregiving-Chronicles/caregiving-in-the-21st-century-how-21st-century-technology-is-streamlining-life-for-the-20th-century-generations>



**PATIENT 4:** 45-year-old patient meets with staff of an FQHC clinic to be fitted for/educated about a remote monitoring device on the 15th of the month and undergoes monitoring that lasts through the 16th of the next month (30 days). The physician interprets the data and communicates to the patient about changing her regimen. *Insurance: Medi-Cal.*

## CODE IT:

There is nothing to be billed with regard to RPM. The place of treatment is at an FQHC; however, the visit with the patient can be billed.



**PATIENT 5:** 74-year-old man has consented to eConsult. Primary care physician (PCP) prepares question to a specialist. Specialist responds back to the PCP and PCP contacts patient to engage in care plan per the specialist's recommendations. *Insurance: Medicare*

## CODE IT:

**PCP Coder:** The PCP documented the question, received the information back, and communicated the findings and care plan back to the patient. The PCP documented 35 minutes of time (Medicare rule of thumb: if code requires 30 minutes, at least over half the time must be spent on the task).

	MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER
1	QUALIFIER + NDC OR UPN								UNIT QUALIFIER AND QUANTITY	
	DOS FROM		DOS THRU			POS	DELAY EMER	PROC CODE	MODIFIERS	
2	01	15	19	01	15	19	11		99452	
3										

**Specialist Consultant Coder:** the specialist, located at a tertiary care center in a facility-based clinic, documented the response and indicated at least 5 minutes of time was spent in the consideration of the reported findings and in responding to the question.

	MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER
1	QUALIFIER + NDC OR UPN								UNIT QUALIFIER AND QUANTITY	
	DOS FROM		DOS THRU			POS	DELAY EMER	PROC CODE	MOD	
2	01	15	19	01	15	19	22		99451	



**PATIENT 6:** 35-year-old man has consented to eConsult. Primary care physician (PCP) prepares question to a specialist. Specialist responds back to the PCP and PCP contacts patient to engage in care plan per the specialist's recommendations. *Insurance: Medi-Cal*

## CODE IT:

**PCP Coder:** The coder has nothing to do. Medi-Cal only reimburses for the specialist's activities. However, a follow-up visit might be done if there is follow-up activity advised by the specialist that the PCP can act on.

**Specialist Consultant Coder:** Same scenario as for Patient 5, above.



**PATIENT 7:** 65-year-old woman discusses results of genetic testing regarding cancer diagnosis with a Genetic Counselor at a facility-based cancer center. *Insurance: Medicare*

## CODE IT:

Medicare does not cover genetic counseling services, as the provider type is not included on its list of eligible telehealth providers. Submit the service on the UB-04 with the GY modifier.

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS
780	Telehealth-General	96040-GT, GY	01/23/19	1



**PATIENT 8:** 36-year-old woman discusses results of genetic testing during pregnancy with a Genetic Counselor at a facility. *Insurance: Medi-Cal*

## CODE IT:

Medi-Cal reimburses for genetic counselors (as does GHPP/CCS). Submit with the 96040, which is the CPT code billed in 30-minute increments for genetic counseling.

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS
780	Telehealth-General	96040-GT	01/23/19	1

## CONCLUSION

We hope that this overview of telehealth provided you with greater clarity in billing telehealth and gives you a starting point for your endeavors. Remember that the basis for commercial billing starts with Medicare and Medicaid programs, as well as the state regulations and policies that advise those carriers on how to conduct their businesses. Until telehealth is considered a mode of care as opposed to a separate type of service, what can and cannot be billed and reimbursed will vary.



## RESOURCES

For more information about your state, please contact your Regional Telehealth Resource Center (RTRC).

<b>California Telehealth Resource Center</b> <i>(California)</i> <a href="http://www.caltrc.org">www.caltrc.org</a> 1-877-590-8144	<b>South Central Telehealth Resource Center</b> <i>(Arkansas, Mississippi, Tennessee)</i> <a href="http://www.learntelehealth.org">www.learntelehealth.org</a> 1-855-664-3450
<b>Great Plains Telehealth Resource &amp; Assistance Center</b> <i>(Iowa, Minnesota, Nebraska, North Dakota, South Dakota, Wisconsin)</i> <a href="http://www.gptrac.org">www.gptrac.org</a> 1-888-239-7092	<b>Southeast Telehealth Resource Center</b> <i>(Alabama, Florida, Georgia, South Carolina)</i> <a href="http://www.setrc.us">www.setrc.us</a> 1-888-738-7210
<b>Heartland Telehealth Resource Center</b> <i>(Kansas, Missouri, Oklahoma)</i> <a href="http://www.heartlandtrc.org">www.heartlandtrc.org</a> 1-877-653-4872	<b>Southwest Telehealth Resource Center</b> <i>(Arizona, Colorado, Nevada, New Mexico, Utah)</i> <a href="http://www.southwesttrc.org">www.southwesttrc.org</a> 1-877-535-6166
<b>Mid-Atlantic Telehealth Resource Center</b> <i>(Delaware, Kentucky, Maryland, New Jersey, North Carolina, Pennsylvania, Virginia, West Virginia, District of Columbia)</i> <a href="http://www.matrc.org">www.matrc.org</a> 434-906-4960	<b>TexLa Telehealth Resource Center</b> <i>(Louisiana &amp; Texas)</i> <a href="http://www.texlatrc.org">www.texlatrc.org</a> 1-877-391-0487
<b>Northeast Telehealth Resource Center</b> <i>(Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont)</i> <a href="http://www.netrc.org">www.netrc.org</a> 1-800-379-2021	<b>Upper Midwest Telehealth Resource Center</b> <i>(Illinois, Indiana, Michigan, Ohio)</i> <a href="http://www.umtrc.org">www.umtrc.org</a> 1-855-283-3734, ext. 231
<b>Northwest Regional Telehealth Resource Center</b> <i>(Alaska, Idaho, Montana, Oregon, Utah, Washington, Wyoming)</i> <a href="http://www.nrtrc.org">www.nrtrc.org</a> 1-833-747-0643	<b>Center for Connected Health Policy (National Policy TRC)</b> <a href="http://www.cchpca.org">www.cchpca.org</a> 1-877-707-7172
<b>Pacific Basin Telehealth Resource Center</b> <i>(Hawaii &amp; US Affiliated Pacific Islands)</i> <a href="http://www.pbtrc.org">www.pbtrc.org</a> 1-808-956-2897	<b>Telehealth Technology Assessment Center (National Technology TRC)</b> <a href="http://www.telehealthtechnology.org">www.telehealthtechnology.org</a> 1-907-726-4703

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