

Medicare Telehealth Reimbursement Summary



The Centers for Medicare and Medicaid Services (CMS) sets federal guidelines for telehealth reimbursement for Medicare patients. Medicare pays for certain provider types and certain outpatient professional services (CPT codes) for patients accessing care from sites in rural counties and HPSAs in rural census tracts. CMS updated their policies annually. New codes become effective on January 1st each new calendar year.

The Fact Sheet linked below provides an excellent summary of the providers, sites, and services (including CPT codes) that are eligible for Medicare telemedicine reimbursement. Telemedicine services are reimbursed at the same rate as in-person care, in accordance with the current Medicare fee schedule. In addition to professional fees, an “Originating Site Facility Fee” of approximately \$24 (billable as code Q3014, a separately billable Part B service) is available to eligible originating sites.

The Medicare Telehealth Fact Sheet contains the current policies and covers services:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcfsht.pdf>

Medicare telehealth codes:

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html>

Medicare telehealth reimbursement eligibility for authorized site, refer to:

<http://datawarehouse.hrsa.gov/tools/analyzers/geo/Telehealth.aspx>

For more information, refer to:

<http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>

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Chronic Care Management

While technically not a telehealth code, CMS introduced reimbursement for Chronic Care Management (CCM) Code at the beginning of January 2015. The first CPT Code that was introduced for CCM was 99490. It is to be used when furnishing services to patients with 2 or more chronic conditions expected to last at least 12 months, or until death of the patient, that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. Services must include:

- 20 minutes or more clinical staff time; billable once every 30 days
- Directed by a physician or other qualified health care professional
- Must be furnished during the 30-day billing interval
- Involves the use of technology to manage care

Two additional codes for CCM became effective in January 2017. CPT code 99487 is for CCM services of at least 60 minutes per calendar month. CPT code 99489 is for each additional 30 minutes of CCM services to an individual patient per calendar month.

For more information, see: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>

While 99490 is not a “telehealth code”, it is anticipated to drive many telehealth services that meet its requirements. It may be used to promote:

- Primary Care Redesign
- Expansion of ACOs
- Commercial payer reimbursement for same services

For more information, refer to the CMS MLN bulletin: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>

Medicare changes for Rural Health Clinics (RHCs)

- CMS began reimbursing RHCs for Chronic Care Management starting 1/1/16
- Requires RHCs to start including HCPCS codes on the UB-04 form
- Provides safe harbors from Stark and Kick-back rules for RHCs to help recruit new providers.

For more information, see: <https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2015-fact-sheets-items/2015-07-08.html>

Behavioral Health Integration and the Psychiatric Collaborative Care Model

Effective January 1, 2018, CMS introduced three additional CPT codes for Psychiatric Collaborative Care Services (CoCM). These codes are 99492, 99493, and 99494. CoCM is a model of behavioral health integration that enhances “usual” primary care by adding two key services: care management support for patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving.

CoCM involves the following ‘Care Team Members:

- Treating (Billing) Practitioner – A physician and/or non-physician practitioner (PA, NP, CNS, CNM); typically primary care, but may be of another specialty (e.g., cardiology, oncology)
- Behavioral Health Care Manager – A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the billing practitioner
- Psychiatric Consultant – A medical professional trained in psychiatry and qualified to prescribe the full range of medications
- Beneficiary – The beneficiary is a member of the care team

CMS also introduced the CTP code 99484 to bill monthly services furnished using BHI models of care other than CoCM that similarly include “core” service elements such as systematic assessment and monitoring, care plan revision for patients whose condition is not improving adequately, and a continuous relationship with a designated care team member.

For more information see: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf>

And: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf>