Telemedicine & Telehealth Reference Guide

A comprehensive resource to master telemedicine coding, compliance, and reimbursement

SECOND EDITION
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With the right tools and utilization, telemedicine will boost both workflow and income. Telemedicine can be a boon for those left behind by hospital consolidations and rural areas lacking medical resources. Furthermore, telemedicine can become an essential tool when managing large scale health emergencies. However, telemedicine is more than just a replacement of an office visit, and it’s not for everyone. Both the provider and the patient must be on board, and depending on the type of telemedicine you’re practicing, the upfront hardware costs can be high.

What’s more, serving patients remotely can be a compliance nightmare if your tools aren’t user-friendly or lack the proper security protocols to ensure the process is both safe and compliant. Many factors go into the successful utilization of telemedicine at your practice or facility, but the primary one is educating your staff on how and why to begin using this new form of patient encounter.

Let the Telemedicine & Telehealth Reference Guide show you the way. This guide is packed full of all the basics you need to launch a robust telehealth program and secure reimbursement for your services. The Telemedicine & Telehealth Reference Guide provides an overall view of telemedicine and telehealth along with in-depth information on coding, billing, and compliance for these services. Practice managers and billing and coding specialists will benefit from the many features this guide offers.
types of plans in three healthcare delivery systems (Kaiser, Spectrum and Ministry) that specifically mention coverage of telehealth services and/or areas they cover beyond Medicare’s current telehealth definition.

CMS is currently testing the feasibility of offering more expansive coverage for telehealth via CMS’s Innovation’s Next Generation Accountable Care Organization (ACO) Demonstration. The Next Generation ACO telehealth waiver allows Next Generation ACO beneficiaries to receive telehealth services in their home regardless of whether they are in a rural area. For more information on Next Generation ACO telehealth see https://innovation.cms.gov.

The Medicare Access and CHIP Reauthorization Act (MACRA) legislation enacted in 2015 includes several telehealth provisions. One of the provisions identifies “the use of remote monitoring or telehealth” as an example of an activity that would fall under a care coordination subcategory of the Clinical Practice Improvement Activities performance category under the Merit-Based Incentive Payment System (MIPS). MIPS is a Medicare program used for assessing physicians’ and other practitioners’ performance and adjusting payments.

The MACRA provision offers a possible “reward” to your physicians and other practitioners who coordinate care using telehealth modalities, even when direct reimbursement for such activity may not be available. Another provision gives CMS the authority to reimburse providers participating in Advanced Alternative Payment Models (APMs) for telehealth services. Under MACRA, eligible providers participating in a qualifying APM will have the capacity to provide a broad array of services at a distance using many different telehealth modalities irrespective of the physical location of the patient or the provider.

Keep in mind, the Medicare fee-for-service program only reimburses for telehealth, which it requires to be delivered by a video-link and when the patient is at a certified healthcare facility in a Health Professional Shortage Area (HPSA).

Medicare Telehealth Services
The use of a telecommunication system for office visits, office psychiatry services, consultations, and certain other medical or health services can be used to substitute an in-person encounter in rural areas.

Consultations
Emergency department and inpatient consultations are services to obtain advice or an opinion from another provider. The provider who furnishes the consultation via telehealth cannot be the physician of record or the attending physician and the consultation must be distinct from the care provided by the physician of record or the attending physician. These services can be provided to Medicare beneficiaries in hospitals or SNFs when the requirements of a consultation code are met. Requirements include:

- The service is separate from the inpatient or emergency department E/M services.
- The provider requests the advice or opinion of another provider.
- The request for the consultation must be documented by the consultant in the patient’s medical record and included in the requesting provider’s plan of care in the patient’s medical record.
- The consultant must document a written report of the findings and recommendations and provide it to the referring physician.
Successful Implementation of Telemedicine and Telehealth at Your Facility

Inventions and improvements in computer technology are moving at lightning speed. New products and devices are constantly being introduced. Wonder how these changes impact you and your facility or practice? These products can be useful to you in several different ways: to capture, store, transfer, and retrieve medical data from anywhere on earth, ultimately providing you and your patients with several more options when it comes to the management or treatment of their disease.

Note: The American Hospital Association (AHA) published a report in 2019 entitled "Telehealth A Path to Virtual Integrated Care." This report examines telehealth as part of the digital healthcare revolution, explaining how telehealth is critical to the future of healthcare and how hospitals and health systems can expand telehealth access and reduce the costs of its use.

Between 2010 and 2017 the use of telehealth in hospitals has grown rapidly. The percent of hospitals fully or partially implementing computerized telehealth systems in 2010-2017 is shown in Figure 4-1.

Source: 2011 to 2018 AHA Annual Survey IT Supplement

Figure 4-1: The Percent of Hospitals Utilizing Computerized Telehealth Systems from 2010-2017

How to Implement Telehealth Services

With the increasing number of facilities using telehealth to improve their patient care and outcomes, you don’t want to be left behind. To grow your practice or facility and keep up with the changing needs of your consumers — both
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hub site</td>
<td>A hub site is defined as the telehealth site where the provider/specialist is located. Other names for this term include distant site, specialty site, provider/physician site, consulting site, or referral site.</td>
</tr>
<tr>
<td>Informatics</td>
<td>Utilizing computer science and information technology to process and manage information and data.</td>
</tr>
<tr>
<td>Integrated services digital network (ISDN)</td>
<td>A dial-up transmission path used for videoconferencing. Per minute charges are accumulated for ISDN services at a contracted rate. The site placing the call is billed. Connections of up to 128Kbps are permitted by ISDN.</td>
</tr>
<tr>
<td>Internet protocol (IP)</td>
<td>A unique address for every computer connected to the internet. The IP address for a videoconferencing system is its telephone number.</td>
</tr>
<tr>
<td>Interoperability</td>
<td>Two or more systems capable of interacting with each other to exchange information.</td>
</tr>
<tr>
<td>Mobile telehealth clinic</td>
<td>A vehicle, such as trailer or van, used to provide healthcare services for patients. Many of these units are equipped with mobile CT, MRI, and teledentistry capabilities.</td>
</tr>
<tr>
<td>Modem</td>
<td>A device that translates an analog signal to digital signals and vice versa. This enables data transmission over telephone lines and as a result allows computers to communicate with one another.</td>
</tr>
<tr>
<td>Multi-point teleconferencing</td>
<td>The process of linking numerous users from different sites. It requires the use of a multi-point control unit or bridge to allow the different sites to videoconference.</td>
</tr>
<tr>
<td>Originating site</td>
<td>This is the site where the patient is located during the telehealth encounter or consult. Other names for this term include spoke site, patient site, remote site, and rural site.</td>
</tr>
<tr>
<td>Patient exam cameras</td>
<td>The cameras used to examine the patient. These can be handheld cameras, camcorders, gooseneck cameras, or webcams.</td>
</tr>
<tr>
<td>Peripheral device</td>
<td>A device used to monitor or view information about a patient. Examples of peripheral devices include mouse pointers, keyboards, video camera, scanner and monitors and medical devices such as blood pressure monitors, ophthalmoscopes, document cameras, weight scales, and pulse oximeters.</td>
</tr>
<tr>
<td>Picture archiving and communications system (PACS)</td>
<td>A system used for the procurement, storing, transmission, and presentation of CT, X-ray, ultrasound, and MRI imagery.</td>
</tr>
<tr>
<td>Presenters or patient presenters</td>
<td>Healthcare professionals, such as registered nurses and licensed practical nurses, who assist in providing telemedicine services, including diagnostic services to patients. These individuals are trained in the use of cameras and computers and are the ones who ultimately communicate for the patients at the originating site.</td>
</tr>
<tr>
<td>Real time</td>
<td>A consultation or encounter where both parties are interacting simultaneously. Real-time telemedicine is commonly conducted with full motion videoconferencing.</td>
</tr>
<tr>
<td>Remote monitoring</td>
<td>The use of measuring devices linked via a communications medium, such as a phone line, that remotely collects and transmits data to a provider for monitoring and interpretation. Remote monitoring is typically used for assessing vital signs, such as ECG data, glucose levels, blood pressure, and weight.</td>
</tr>
<tr>
<td>Router</td>
<td>A device that provides connection to at least two network sites. It is responsible in finding the best route between these two sites. A router “tells” the videoconferencing devices where the destination devices are located and finds the best way to gather the data from that specific location.</td>
</tr>
<tr>
<td>Secure messaging</td>
<td>The use of a secure email server to electronically communicate directly with the patient. Secure messaging is not reimbursed by Medicare because it is considered an alternative to telephone calls between the patient and provider. However, this does not prohibit providers from using secure messaging if it is viewed as a more efficient means for communication.</td>
</tr>
<tr>
<td>Spoke site</td>
<td>This is the site where the patient is located during the telehealth encounter or consult. Other names for this term include originating site, patient site, remote site, and rural site.</td>
</tr>
</tbody>
</table>
### APPENDIX A

**Glossary of Telemedicine and Telehealth Terminology**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Store and forward</strong></td>
<td>The asynchronous technology transfer of data from one site to another using a camera or similar device that records (stores) an image that is then sent (forwarded) via telecommunication to another site. Specialties that commonly use store and forward technology include radiology, dermatology, and wound care. It may also be used to transfer patients’ clinical data (blood test results and ECG) from the patient’s location to the hospital.</td>
</tr>
<tr>
<td><strong>Synchronous</strong></td>
<td>The interactive video connection between two locations, with information being transmitted simultaneously from both directions.</td>
</tr>
<tr>
<td><strong>Telecardiology</strong></td>
<td>A specialized use of store and forward technology that transmits cardiac data between a remote location and a specialist’s site. Examples include data from echocardiograph readings, radiographic images, and/or digital stethoscope auscultation.</td>
</tr>
<tr>
<td><strong>Telecolposcopy</strong></td>
<td>A specialized use of telemedicine that provides review and diagnosis of cervical cancer screening. This typically involves the transmission of store and forward imagery, but can also include a real-time consultation.</td>
</tr>
<tr>
<td><strong>Telecommunications</strong></td>
<td>The transmission and reception of video, audio, or other data over a distance. There are several components that make up a telecommunications system. Examples include a transmitter, a transmission medium, and a specific channel on which to transmit. Telecommunications can operate from one location to another (point-to-point), from multiple locations (multipoint), or as a one-way transmission from a sender to multiple receivers (broadcast).</td>
</tr>
<tr>
<td><strong>Teleconferencing</strong></td>
<td>An interaction between multiple users across various sites using electronic communication equipment involving the transfer of audio and video. Teleconferencing occurs in real time and is most often used to diagnosis or monitor a home healthcare patient.</td>
</tr>
<tr>
<td><strong>Teleconsultation</strong></td>
<td>A consultation between a specialist and a provider at different locations. This can be accomplished using either store and forward telemedicine or real-time videoconferencing.</td>
</tr>
<tr>
<td><strong>Teledentistry</strong></td>
<td>A specialized use of telemedicine that allows for remote access to a patient for the purposes of monitoring or diagnosing dental issues.</td>
</tr>
<tr>
<td><strong>Teledermatology</strong></td>
<td>A specialized use of telemedicine that offers dermatological care at a distance. Diagnoses can be made using digital images or though real-time consultations.</td>
</tr>
<tr>
<td><strong>Teledisease</strong></td>
<td>A form of remote disease management accomplished by a variety of monitoring devices that rarely require video capabilities.</td>
</tr>
<tr>
<td><strong>Telehealth</strong></td>
<td>Describes the use of telecommunications technology to send medical information from one place to another with the goal of improving a patient’s health through diagnosis or monitoring.</td>
</tr>
<tr>
<td><strong>Telemedicine</strong></td>
<td>A real-time encounter between patient and provider, for monitoring or diagnosing a condition, that uses video equipment as the means for communication.</td>
</tr>
<tr>
<td><strong>Telementoring</strong></td>
<td>A means of remotely offering individual guidance to a peer. One example would be a doctor mentoring another healthcare provider who is new to the industry.</td>
</tr>
<tr>
<td><strong>Telemonitoring</strong></td>
<td>Using audio, video, or other electronic telecommunication systems to share real-time information between computers with the goal of monitoring the health of a patient remotely. Home healthcare is one example of a service that benefits from the use of this technology.</td>
</tr>
<tr>
<td><strong>Telematics</strong></td>
<td>The integration of information processing that is based on a computer and uses telecommunications for programs and data transfer between computers.</td>
</tr>
<tr>
<td><strong>Telemetry</strong></td>
<td>Measurement and transmission of a patient’s healthcare data via telecommunications systems to a provider’s location for analysis and decision making.</td>
</tr>
<tr>
<td><strong>Teleneurology</strong></td>
<td>A specialized use of telemedicine that provides remote neurological care. This can be beneficial for gait assessments and/or follow-up treatments for stroke patients.</td>
</tr>
<tr>
<td><strong>Telenutrition</strong></td>
<td>The counseling and monitoring a patient’s nutritional progress from their home or other remote location.</td>
</tr>
<tr>
<td><strong>Teleophthalmology</strong></td>
<td>The utilization of telemedicine devices to study and diagnose eye diseases from a remote location.</td>
</tr>
<tr>
<td><strong>Telepathology</strong></td>
<td>The process of viewing pathological specimens remotely to diagnose a disease.</td>
</tr>
</tbody>
</table>
results as face-to-face therapy for bulimia nervosa, PTSD, and depression and can be considered a viable alternative when face-to-face therapy is not accessible. Furthermore, research on telepsychiatry utilization in rural nursing homes found cost savings for the psychiatrist, nursing homes, and patients, in addition to enthusiastic support from patients, family members, and nursing home personnel.

**Substance Use**

In 2014, approximately 21.2 million individuals in the U.S. had a substance use disorder (SUD), but only 2.5 percent of those individuals received treatment. It is estimated that the number of adults aged 50 years and older who will have an SUD by 2020 could be between 4.4 million to 5.7 million individuals. The Medicare population has among the highest and fastest-growing rates of opioid use disorders, currently more than 6 of every 1,000 beneficiaries. Many seniors take multiple medications and receive prescriptions from multiple doctors, making tracking and controlling any misuse of these prescriptions a substantial challenge.

Research into county-level access to treatment facilities showed that there were lower proportions of treatment facilities in southern and Midwestern states than in other regions. Furthermore, it is estimated that outpatient SUD treatment services are almost four times less likely to be available in rural hospitals than in urban hospitals (12.1 percent versus 43.7 percent, respectively, with treatment services offered either directly or by arrangement). In addition, hospitals in large rural areas are about twice as likely to offer SUD treatment services (17.9 percent) as hospitals in small (8.2 percent) or isolated (8.5 percent) rural areas.

Rural areas are particularly short on detoxification (detox) services. A survey conducted by the Maine Rural Health Research Center in 2008 found that 82% of rural residents live in a county without a detox provider. More than half of all rural detox providers serve patients across a 100 mile radius limiting referral options to SUD treatment, especially in isolated rural areas.

Although not specific to Medicare, a preliminary study that compared a videoconferencing telehealth SUD treatment program with a comparable in-person counterpart found that the completion rates were double for the online version compared with traditional outpatient treatment (80 percent versus 41 percent, respectively). Additional studies suggest that the reasons for increased completion rates using telehealth programs may be convenience and increased confidentiality. Research has also found telehealth SUD services to be as effective as in-person treatment, although small sample sizes are a recurring limitation to determining statistically significant results.

**Opioids**

Opioid misuse has emerged as the most serious substance abuse epidemic in the U.S. in the past few years. Opioid medications include narcotics intended to manage pain resulting from injury, illness, or surgery. While opioid misuse often derives from the long-term management of chronic pain with opioid treatment, opioid overdoses were responsible for 63 percent (33,091) of all drug overdose deaths in the U.S. in 2015. As previously discussed, the Medicare population has among the highest and fastest-growing rates of opioid use disorders, currently more than 6 of every 1,000 beneficiaries. Chronic pain—pain lasting longer than three continuous months or past the normal amount of time for tissue to heal—is most often managed with opioid medications. The risk of opioid dependence is believed to substantially increase when opioids are used continuously for three months, so the risk that individuals with chronic pain using opioids face in developing a dependence is high.

A recent report published by the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) notes that one of every three Medicare Part D beneficiaries (14.4 million individuals) received at least one prescription for opioids in 2016, totaling $4.1 billion in costs to Medicare. Five million beneficiaries received opioids for at least 3 months, and of these 5 million beneficiaries, 3.6 million received opioids for 6 or more months and some 610,000 received opioids for the entire year. Furthermore, OIG warns that nearly 90,000 Medicare beneficiaries run a serious risk of misusing opioids or overdosing because of the number of beneficiaries using extreme opioid doses (69,563 individuals) or appearing to be “doctor shopping” for opioid medication (22,308 individuals). More than 2,000 beneficiaries are present in both of these groups.

Every geographic region, population, and age group has been impacted by the opioid epidemic, including Medicare beneficiaries, but treatment barriers persist throughout the country. Although individuals living in rural areas report higher rates of prescription opioid misuse than urban residents, only about 3 percent of all opioid treatment programs are located in rural areas. Telehealth may serve as a valuable tool to improve access to evidence-based treatment, including for Medicare beneficiaries. Telehealth has the potential to help bridge the rural-urban treatment gap for Medicare beneficiaries by linking rural clients to high-quality behavioral health services and providers located in more populated areas. Telehealth seems to provide the intervention most similar to office-based treatment, and research shows that telehealth patients, while not specific to Medicare, have satisfaction levels and outcomes similar to those of clients receiving in-person therapy.
### Table E-7: Telehealth Services by Type, 2014-2016

<table>
<thead>
<tr>
<th>Type of Telehealth Service</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Percent Change 2014-2016 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visits</td>
<td>115,064</td>
<td>139,519</td>
<td>172,577</td>
<td>50.0</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>19,859</td>
<td>32,122</td>
<td>53,663</td>
<td>170.2</td>
</tr>
<tr>
<td>Psychiatric diagnostic interview examination</td>
<td>12,644</td>
<td>14,008</td>
<td>14,190</td>
<td>12.2</td>
</tr>
<tr>
<td>Telehealth consultations, emergency department or initial inpatient</td>
<td>7,592</td>
<td>11,185</td>
<td>11,243</td>
<td>48.1</td>
</tr>
<tr>
<td>Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days</td>
<td>3,313</td>
<td>6,339</td>
<td>9,491</td>
<td>186.5</td>
</tr>
<tr>
<td>Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days</td>
<td>4,858</td>
<td>6,696</td>
<td>7,254</td>
<td>49.3</td>
</tr>
<tr>
<td>Telehealth pharmacologic management</td>
<td>1,745</td>
<td>2,842</td>
<td>3,888</td>
<td>122.8</td>
</tr>
<tr>
<td>End-stage renal disease (ESRD)-related services</td>
<td>1,077</td>
<td>2,066</td>
<td>1,620</td>
<td>50.4</td>
</tr>
<tr>
<td>Neurobehavioral status examination</td>
<td>33</td>
<td>136</td>
<td>267</td>
<td>709.1</td>
</tr>
<tr>
<td>Other</td>
<td>327</td>
<td>470</td>
<td>1,006</td>
<td>207.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>275,199</td>
<td>355,168</td>
<td>395,255</td>
<td></td>
</tr>
</tbody>
</table>

Source: NORC and KPMG Analysis of CMS Medicare Research Identifiable Files

Table E-8 shows the annual magnitude of the high-volume services that are furnished through face-to-face encounters and for the same services that were delivered through telehealth. This claims analysis identified just over 243 million in-person office or outpatient visits and almost 100 million hospital and nursing facility consultations. In fact, three of the top ten national services appear in the categories above, established outpatient visits of 15 or 25 minutes and subsequent hospital inpatient care of 25 minutes.

These are the most common durations of visits for new and/or established Medicare patients. On average, the 35.1 million FFS beneficiaries included in this analysis received seven Office or Other Outpatient visits in 2016. Additionally, almost 15 million mental health evaluations and therapy sessions were received by Medicare FFS beneficiaries.

### Table E-8: In-person and Telehealth Delivery of Common Services by Type, 2016

<table>
<thead>
<tr>
<th>Delivery of Common Telehealth Services by Type*</th>
<th>Telehealth Delivery</th>
<th>In-person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visits</td>
<td>172,577</td>
<td>243,259,924</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>53,663</td>
<td>13,724,561</td>
</tr>
<tr>
<td>Psychiatric diagnostic interview examination</td>
<td>14,190</td>
<td>1,328,021</td>
</tr>
<tr>
<td>Telehealth consultations, emergency department or initial inpatient</td>
<td>11,243</td>
<td>n/a</td>
</tr>
<tr>
<td>Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days</td>
<td>9,491</td>
<td>21,708,906</td>
</tr>
<tr>
<td>Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days</td>
<td>7,254</td>
<td>72,209,653</td>
</tr>
<tr>
<td>Telehealth pharmacologic management</td>
<td>3,888</td>
<td>n/a</td>
</tr>
<tr>
<td>End-stage renal disease (ESRD)-related services</td>
<td>1,620</td>
<td>2,824,931</td>
</tr>
<tr>
<td>Neurobehavioral status examination</td>
<td>267</td>
<td>112,930</td>
</tr>
<tr>
<td>Other</td>
<td>1,006</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>275,199</td>
<td>355,168,926</td>
</tr>
</tbody>
</table>

Source: NORC and KPMG Analysis of CMS Medicare Research Identifiable Files

* A complete table of the volume of non-telehealth services is included in Appendix D

Table E-8: In-person and Telehealth Delivery of Common Services by Type, 2016
### General Provider Telehealth and Telemedicine Tool Kit

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>List of Resources</th>
</tr>
</thead>
</table>

The specific 1135 waiver requests should go to that CMS Location. Email addresses for our Regional Offices are listed below:  
- **ROATLHSQ@cms.hhs.gov** (Atlanta RO): Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.  
- **RODALDSC@cms.hhs.gov** (Dallas RO): Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.  
- **ROCHISC@cms.hhs.gov** (Midwest Consortium): Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, and Nebraska.  
- HCPCS codes and the Physician Fee Schedule: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes |

Note, this toolkit is designed to provide information only and not intended to endorse any non-federal entities.
In the event of a disaster or public health emergency, state Medicaid agencies should contact CMS for questions and waiver requests. More information on this process is located at: https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html

**Special Waivers**

**EMTALA:**
Only two aspects of the EMTALA requirements can be waived under 1135 Waiver Authority: 1) Transfer of an individual who has not been stabilized, if the transfer arises out of an emergency or, 2) Redirection to another location (offsite alternate screening location) to receive a medical screening exam under a state emergency preparedness or pandemic plan. A waiver of EMTALA sanctions is effective only if actions under the waiver do not discriminate as to source of payment or ability to pay. Hospitals are generally able to manage the separation and flow of potentially infectious patients through alternate screening locations on the hospital campus.

Therefore, waivers to provide Medical Screening Examinations at an offsite alternate screening location not owned or operated by the hospital will be reviewed on a case by case basis. Please note, there is no waiver authority available for any other EMTALA requirement.

For the duration of the COVID-19 national emergency, CMS is waiving the enforcement of section 1867(a) of the Social Security Act (the Emergency Medical Treatment and Active Labor Act, or EMTALA). This will allow hospitals, psychiatric hospitals, and CAHs to screen patients at a location offsite from the hospital’s campus to prevent the spread of COVID-19, in accordance with the state emergency preparedness or pandemic plan.

**Individual Physician Self-Referral Law Waiver Requests:**
CMS has issued blanket waivers of sanctions under the physician self-referral law. The blanket waivers may be used now without notifying CMS. For more information, visit: https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Spotlight.

Unlike other 1135 waiver requests, any requests for individual waivers of sanctions under the physician self-referral law related to COVID-19 will be handled by CMS Baltimore. Please send your request to 1877CallCenter@cms.hhs.gov and include the words “Request for 1877(g) Waiver” in the subject line of the email. All requests should include the following minimum information:

- Name and address of requesting entity;
- Name, phone number and email address of person designated to represent the entity;
- CMS Certification Number (CCN) or Taxpayer Identification Number (TIN);
- Nature of request.

Individual waivers may be granted only upon request and on a case-by-case basis and require specific details concerning the actual or proposed financial relationship between the referring physician(s) and the referred-to entity. Unless and until a waiver of sanctions under the physician self-referral law (i.e., a waiver of section 1877(g) of the Social Security Act) is granted to the requesting party(ies), such party(ies) must comply with section 1877 of the Social Security Act and the regulations at 42 CFR §411.350 et seq.
Critical access hospitals. When the originating site is a critical access hospital, make payment separately from the cost-based reimbursement methodology. For CAH’s, the payment amount is 80 percent of the originating site facility fee.

Federally qualified health centers (FQHCs) and rural health clinics (RHCs). The originating site facility fee for telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.

Physicians’ and practitioners’ offices. When the originating site is a physician’s or practitioner’s office, the payment amount, in accordance with the law, is the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee, regardless of geographic location. The A/B MAC (B) shall not apply the geographic practice cost index (GPCI) to the originating site facility fee. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the MPFS.

Hospital-based or critical access hospital based renal dialysis center (or their satellites). When a hospital-based or critical access hospital based renal dialysis center (or their satellites) serves as the originating site, the originating site facility fee is covered in addition to any composite rate or MCP amount.

Skilled nursing facility (SNF). The originating site facility fee is outside the SNF prospective payment system bundle and, as such, is not subject to SNF consolidated billing. The originating site facility fee is a separately billable Part B payment.

Community Mental Health Center (CMHC). The originating site facility fee is not a partial hospitalization service. The originating site facility fee does not count towards the number of services used to determine payment for partial hospitalization services. The originating site facility fee is not bundled in the per diem payment for partial hospitalization. The originating site facility fee is a separately billable Part B payment.

To receive the originating facility site fee, the provider submits claims with HCPCS code “Q3014, telehealth originating site facility fee”; short description “telehealth facility fee.” The type of service for the telehealth originating site facility fee is “9, other items and services.” For A/B MAC (B) processed claims, the “office” place of service (code 11) is the only payable setting for code Q3014. There is no participation payment differential for code Q3014. Deductible and coinsurance rules apply to Q3014. By submitting Q3014 HCPCS code, the originating site authenticates they are located in either a rural HPSA or non-MSA county.

This benefit may be billed on bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, and 85X. Unless otherwise applicable, report the originating site facility fee under revenue code 078X and include HCPCS code “Q3014, telehealth originating site facility fee.”

Hospitals and critical access hospitals bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in inpatient hospitals must be submitted on a 12X TOB using the date of discharge as the line item date of service.

Independent and provider-based RHCs and FQHCs bill the appropriate A/B/MAC (A) using the RHC or FQHC bill type and billing number. HCPCS code Q3014 is the only non-RHC/FQHC service that is billed using the clinic/center bill type and provider number. All RHCs and FQHCs must use revenue code 078X when billing for the originating site facility fee. For all other non-RHC/FQHC services, provider based RHCs and FQHCs must bill using the base provider’s bill type and billing number. Independent RHCs and FQHCs must bill the A/B MAC (B) for all other non-RHC/FQHC services. If an RHC/FQHC visit occurs on the same day as a telehealth service, the RHC/FQHC serving as an originating site must bill for HCPCS code Q3014 telehealth originating site facility fee on a separate revenue line from the RHC/FQHC visit using revenue code 078X.

Hospital-based or CAH-based renal dialysis centers (including satellites) bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in renal dialysis centers must be submitted on a 72X TOB. All hospital-based or CAH-based renal dialysis centers (including satellites) must use revenue code 078X when billing for the originating site facility fee. The renal dialysis center serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary.

Skilled nursing facilities (SNFs) bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in SNFs must be submitted on TOB 22X or 23X. For SNF inpatients in a covered Part A stay, the originating site facility fee must be submitted on a 22X TOB. All SNFs must use revenue code 078X when billing for the originating site facility fee. The SNF serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary.
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