

Telemedicine Reimbursement Handbook



... c o n n e c t i o n s ...

The **California Telemedicine & eHealth Center (CTEC)** is a statewide organization dedicated to improving the healthcare of underserved communities through the use of innovative health technology solutions.

CTEC is funded by the following agencies:

The California Endowment

Blue Shield of California Foundation

Office for the Advancement of Telehealth

Since inception in 1997, CTEC has become a leader in the statewide development of telemedicine and eHealth programs and is a primary source of support for hospitals and clinics developing telemedicine and eHealth programs to address health care needs in rural and underserved communities. CTEC serves as one of five federally designated Regional Telehealth Resource Centers, providing training and technical assistance to encourage the growth of telemedicine and eHealth programs statewide.

For more information about CTEC, please visit our web site at *www.cteonline.org*.

Information Disclaimer

The information provided in this handbook is meant to be general summary information on telemedicine reimbursement. It is recommended that those who work with health plans contact their contracting resources to seek definitive information as to how to bill for telemedicine services.

Acknowledgements

This handbook was made possible by support from The California Endowment and by grant number G55TH07770 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS. This publication was reviewed and edited by the staff of the California Telemedicine & eHealth Center, including:

Christine Martin, Executive Director

Irene Alvarez, Program Director

Steve Fowler, Technical Manager

Sabrina Johnson, Grants Manager

CTEC would also like to acknowledge the following members of the CTEC Advisory Committee for their valuable contributions to this publication:

Bridget Cole, Director of Information Technology and Special Projects, Comprehensive Community Health Centers. Inc.

Jorge Cuadros, OD, Director of Informatics Research, University of California, Berkeley, School of Optometry

Dean Germano, Chief Executive Officer, Shasta Community Health Center

Tom Nesbitt, MD, Assistant Dean of Regional Affiliations, Rural Outreach & Telehealth, UC Davis Health System

Hermann Spetzler, Executive Director, Open Door Community Health Centers

TABLE OF CONTENTS

- The Impact of State Legislation on Telemedicine Reimbursement** 5
- Understanding Telemedicine Legal and Regulatory Issues** 7
 - Privacy and Security
 - Credentialing and Privileging of Providers
 - Provider Licensing
 - Patient Consent
- Major Payers for Telemedicine Reimbursement** 10
 - Federal and State Programs**
 - Medicare 10
 - Federally Qualified Health Centers 14
 - Medicaid (Medi-Cal) 15
 - Healthy Families 22
 - California Children’s Services 22
 - County Medical Services Program 25
 - Commercial or Private Insurance**
 - Blue Cross of California 26
- Appendices**
 - Appendix A - Listing of HPSAs for Medicare Coverage 40
 - Appendix B - Listing of CPT Codes by Payer 55
- Glossary of Terms** 57
- References** 60

The Impact of State Legislation on Telemedicine Reimbursement

Telemedicine is the provision of patient care and consultation over a distance, using telecommunications technology. Thus, the patient and provider delivering care do not have to be in close proximity, which is often of particular benefit to those in rural areas without access to the full spectrum of health care specialists. It should be noted however, that Telemedicine is beneficial in both rural and urban settings, although Medicare does not cover Telemedicine services provided in non-rural settings.

Telemedicine has been recognized as part of an approach to address the problem of provider distribution and the development of health systems in medically underserved areas by improving communication capabilities and providing convenient access to up-to-date information, consultations, and other forms of support.

It was recognized that Telemedicine:

- Has the potential to reduce costs, improve quality and improve access;
- Has been utilized in one form or another for 30+ years;
- Will assist in maintaining or improving the physical and economic health of underserved communities by keeping the source of medical care in local areas and preserving health care-related jobs;
- Provides consumers with benefits from expanded access to providers, faster and more convenient treatment, better continuity of care, reduction of lost work time and travel costs;
- Does not change the existing scope of practice of any licensed health professional; and
- Does not replace health care providers but preserves and enhances the provider-patient relationship.

Telemedicine is not a telephone conversation or a fax. Instead, Telemedicine typically involves the application of both video and audio technologies in support of healthcare delivery. The lack of payment for Telemedicine services is considered to be one of the major barriers to Telemedicine's rapid deployment. The ability to bill and collect fees for providing clinical services via Telemedicine is a huge issue for sustaining a Telemedicine program.

Senate Bill 1665 enacted the "Telemedicine Development Act of 1996" and imposed several requirements governing the delivery of health care services through Telemedicine. The legislation defined Telemedicine as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. It defined "interactive" as a means involving a real-time (synchronous) or store-and-forward (asynchronous) two-way transfer of medical data and information. The bill prohibits health care service plans from requiring face-to-face contact between a health care provider and a patient for services appropriately provided through Telemedicine. It also authorized reimbursement of Telemedicine services under the Medi-Cal fee-for-service program. The Act required that Medi-Cal recognize the practice of Telemedicine as a legitimate

means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider. Medi-Cal would cover such services that are otherwise covered by the Medi-Cal program.

In December 2000, Congress passed appropriations bill HR 5661, which dramatically revised Medicare rules for reimbursement for Telemedicine services. The legislation, which has been effective since October 2001, has the following features:

- Eliminated the provider “fee sharing” requirement;
- Eliminated the requirement for a Medicare participating “tele-presenter”;
- Allows Originating Sites to be paid a fee to recover facility costs (current fee is \$21.86);
- Expanded Telemedicine services to include direct patient care, physician consultations and office psychiatry services;
- Included payment for physician or practitioner at the Distant Site at the rate applicable to services generally;
- Expanded the definition of Originating Sites to include physician and practitioner offices, critical access hospitals, rural health clinics, federally qualified health centers and hospitals;
- Expanded the geographic regions in which Originating Sites are located to include rural health professional shortage areas, any county not located in a MSA, and from any entity approved for a federal Telemedicine demonstration projects; and
- Permitted the use of Store-and-Forward application in Hawaii and Alaska.

In September 2005, California Legislation passed AB 354, which broadens the definition of Telemedicine services to include “store-and-forward” and expanded Medi-Cal reimbursement to include store-and-forward Telemedicine consultations for Teleophthalmology and Teledermatology. This expansion enables providers to capture and transmit audio clips, still images, or other relevant data that could then be transmitted to a specialist in another location.

As with Medicaid, regulations for Telemedicine reimbursement by private insurers are set by the states. As of June 2003, 23 states have some form of reimbursement for services delivered via telemedicine technologies for interactive consultations to Medicaid recipients.

In California, Medi-Cal recognizes physician consultations (medical and mental health) when furnished using interactive video teleconferencing. Payment is on a fee-for-services basis, which is the same as the reimbursement for covered services furnished in the conventional face-to-face manner. Both consulting and referring providers can be reimbursed for Telemedicine at both the hub and spoke sites.

Understanding Telemedicine Legal and Regulatory Issues

Privacy and Security

Guidance on privacy and security issues is governed by the Health Insurance Portability and Accountability Act (HIPAA). The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services (HHS) to establish national standards for the security of electronic health care information. The final rule adopting HIPAA standards for security was published in the Federal Register on February 20, 2003. This final rule specifies a series of administrative, technical, and physical security procedures for covered entities to use to assure the confidentiality of electronic protected health information. For more information on the national standards for privacy and security please visit www.cms.gov/hipaa/.

Credentialing and Privileging of Providers

In January 2001, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) issued standards for Telemedicine credentialing and privileging of providers, which were later revised in 2004. Currently the standards only apply to hospitals.

- 1) Practitioners who treat patients via Telemedicine must be credentialed with the organization that receives the Telemedicine service.
- 2) Medical staff of the receiving facility determine which Telemedicine services are appropriate.

The January 2004 revised standards clarify that standards do not apply to Telemedicine providers adhering to a consultative model or interpretive services (radiology and pathology). More recently, JCAHO introduced another revision of its Telemedicine standards, which went into effect on July 1, 2006. According to JCAHO's Web site (www.jcaho.org), standards **MS.4.20** and **MS.4.120** will require hospitals that rely on privileging and credentialing information provided by a JCAHO-accredited ambulatory care organization to ensure that the ambulatory facility is in compliance with revised ambulatory care standards **HR.4.10** through **HR.4.24**. Please visit JCAHO's web site for additional information.

Provider Licensing

The delivery of Telemedicine services within a given state typically is not an issue. However, the delivery of services across state lines can be a major issue. Non-resident practitioners may provide services if in consultation with a California licensed practitioner and the consultant is licensed in the state or country in which he/she resides. Consultants may not open an office, appoint a place to meet patients, receive calls from patients within California, give orders or have ultimate authority over the care or primary diagnosis of a patient.

Patient Consent

According to California Business and Professions Code Section 2290.5, the health care practitioner who has "ultimate authority over the care of primary diagnosis of the patient" must obtain verbal and written informed consent from the patient or the patient's legal representative. The California Hospital Association (CHA) provides the following description of the requirements in its Consent Law Manual.¹

The informed consent procedure must ensure that at least all of the following information is given to the patient or the patient's legal representative verbally and in writing:

- The patient or the patient's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the patient or the patient's legal representative would otherwise be entitled.
- A description of the potential risks, consequences and benefits of Telemedicine.
- All existing confidentiality protections apply.
- All existing laws regarding patient access to medical information and copies medical records apply.
- Dissemination of any patient-identifiable images or information from Telemedicine interaction to researchers or other entities shall not occur without the consent of the patient.
- Patients may withdraw consent for Telemedicine at any time without affecting the right to future care of treatment.
- The patient (or the legal representative) must sign a written statement prior to the delivery of health care via Telemedicine, indicating that the patient understands the written information provided and that this information has been discussed with the health care practitioner, or his or her designee. The signed form must be placed in the medical record. Telemedicine Consent (CHA Form 4-11) complies with these requirements.

This law does not apply in the following situations:

- When the patient is not directly involved in the Telemedicine interaction (for example, when one health care practitioner consults with another health care practitioner).
- In an emergency situation in which a patient is unable to give informed consent and the representative of that patient is not available in a timely manner.
- When a patient is under the jurisdiction of the Department of Corrections or any other correctional facility.

The following page includes a sample authorization and consent form used to obtain participate consent in a telemedicine consultation. This form has been provided on behalf of University of California, Davis Health System.

TELEMEDICINE INPATIENT CONSENT / REFUSAL

NAME _____ UNIT NUMBER _____

**Authorization and Consent to Participate in
Telemedicine Consultation**

1. **PURPOSE.** The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s):
2. **NATURE OF TELEMEDICINE CONSULTATION.** During the telemedicine consultation:
 - a. Details of your medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.
 - b. Physical examination of you may take place.
 - c. Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission.
 - d. Video, audio, and/or photo recordings may be taken of the procedure(s).
3. **MEDICAL INFORMATION AND RECORDS.** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. **CONFIDENTIALITY.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and California law apply to information disclosed during this telemedicine consultation.
5. **RIGHTS.** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting the right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. **DISPUTES.** I agree that any dispute arising from the telemedicine consult will be resolved in California, and that California law shall apply to all disputes.
7. **RISKS, CONSEQUENCES AND BENEFITS.** I have been advised of all the potential risks, consequences and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

Signature: _____
Patient (or patient's legal representative)

I refuse to participate in a telemedicine consultation for the procedure(s) described above.
Signature : _____

Date: _____ Time: _____ A.M. P.M.

If signed by other than patient, indicate relationship: _____

Witness: _____ Date: _____

Major Payors for Telemedicine Reimbursement

MEDICARE

The Center for Medicare and Medicaid Services (CMS) administers Medicare programs in the United States. Currently, Medicare provides coverage to approximately 40 million Americans. Medicare is the national health insurance program for:

- People age 65 or older
- Some people under age 65 with disabilities
- People with End-Stage Renal Disease (ESRD), which is permanent kidney failure requiring dialysis or kidney transplant.

Medicare coverage of Telemedicine/eHealth Services²

- 1) Remote patient face-to-face services seen via live video conferencing
- 2) Non face-to-face services that can be conducted either through video clips or via store-and-forward telecommunication services.
- 3) Home health care services, under specific regulations.

Additionally, national and local coverage determinations may alter or expand the services that are eligible for reimbursement. Store and forward is currently being reimbursed under specific demonstration projects in Alaska and Hawaii.

1) Remote Patient Face-To-Face Interactive Services

CMS defines Telemedicine services to include those services that require a face-to-face meeting with the patient. Reimbursement for these services is limited to the type of services provided, geographic location, type of institution delivering the services and type of health provider.

Since changes arising from the federal Benefits Improvement and Protection Act of 2000 (BIPA) were made effective October 1, 2001, Medicare coverage of Telemedicine services has been significantly expanded.^{3,4} The following information reflects these changes.^{5,6,7}

It should be noted that Medicare coverage is contingent on the use of real time, interactive audio and video telecommunications (Social Security Act §1834M). There is, however, an exception for demonstration sites in Alaska and Hawaii.

Location

The service must be provided to an eligible Medicare beneficiary in an eligible facility (as listed below) located outside of a metropolitan area. However, there is no limitation on the location of the health professional delivering the medical service (referring site).

The patient must be at a patient site that is either:

- A rural Health Professional Shortage Area (HPSA); or,

- A rural county which is a county that is not a Metropolitan Statistical Area (MSA) county; or,
- An entity that participates in a Federal Telemedicine demonstration project.

Thus, if a county is considered rural (non-MSA) for Medicare purposes, any location in the county is considered to be a reimbursable patient site. However, if the county is considered urban (MSA) for Medicare, the patient site must be in a rural (non-metropolitan) HPSA.

Eligible Providers

There are restrictions on the patient or originating sites for Medicare coverage. Only the following health professionals may claim reimbursement for remote Telemedicine services:

- Physician office (as recognized by Medicare)
- Office of one of the following providers:
 - Physician assistant
 - Nurse practitioner
 - Clinical nurse specialist
 - Certified registered nurse anesthetist
 - Certified nurse-midwife
 - Clinical social worker
 - Registered dietitian or nutrition professional
 - Clinical psychologist*
 - Clinical social worker*

*Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.

Eligible Facilities

Only the following facilities are eligible to be an originating site under the rules of the program:

- Office of a physician or practitioner
- Critical access hospital (CAH)
- Rural health clinic (RHC)
- Federal qualified health center (FQHC)
- Hospital (as defined by Medicare, including general acute care hospitals and acute psychiatric hospitals)

Even though there are specific provider types listed as acceptable patient sites, that does not mean the provider such as a physician or nurse practitioner, for example, has to actually present the patient. All of these sites must also meet the location tests as noted above.

Billing and Reimbursement

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided. Additionally, the non-metropolitan facility with the patient is eligible to receive a facility fee. Claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided and the Telemedicine modifier “GT” for interactive audio and video telecommunications system or “GQ” for store-and-forward applications.

Patient Site - Originating Site Facility Fee

The patient site receives a flat reimbursement rate, outside of any other reimbursement arrangement such as inpatient DRGs or RHC per-visit payments. Thus, there must be a separate bill for this service. The billing code is HCPCS code Q3014, “telehealth originating site facility fee,” and is used by any of the approved providers to bill for their service.

The current payment amount is the lesser of the actual charge amount or \$21.86, and usual Medicare beneficiary cost-sharing such as deductibles and co-payments apply. The payment amount is updated on a calendar year basis as part of Medicare’s Physician Fee Schedule annual update.

Consult Site

Medicare reimbursement for the consult site provider is the regular Medicare reimbursement amount for the service. The appropriate CPT code shown previously is billed along with a “GT” modifier for live interactive telemedicine and “GQ” for store and forward applications.

Eligible Medical Services

Services that are eligible for reimbursement include consultation, office visits, individual psychotherapy and pharmacologic management delivered via a telecommunications system. The official CMS policy reads as follows:⁸

The use of a telecommunications system may substitute for a face-to-face, “hands on” encounter for consultation, office visits, individual psychotherapy and pharmacologic management.

Specific CPT codes that are covered include:

Services	CPT Codes
Consultations	99241-99255
Office or other outpatient visits	99201-99215
Individual psychotherapy	90804-90809
Pharmacologic management	90862
Psychiatric diagnostic interview examination	90801

Clinical psychologists and clinical social workers are not allowed to bill for CPT codes 90805, 90807, and 90809.

In addition to the above codes, other codes as discussed below are being used when appropriate.

Scoping Procedures

92504	Binocular Microscopy
92511	Nasopharyngoscopy
31575	Fiberoptic Laryngoscopy
31213	Nasal Endoscopy, Unilateral/Bilateral

The medical peripherals for these procedures (Nasopharyngoscope, flexsigmodoscope, otoscope, slit lamp imager, fundus scope, etc) must be at the patient site.

These diagnostic or treatment services are billed separately from the comprehensive otorhinolaryngologic evaluation; in other words, they are billed as secondary CPT codes. Because these procedures are done at the same time as the consultation and are billed as secondary CPT codes, no GT modifier is required by Medicare.

Nutrition Counseling

Medicare covers nutrition counseling based upon diabetes or other medical conditions while other third party payers may cover these services as obesity-related conditions. Effective January 1, 2006, HCPCS codes G0270, 97802 and 97803 are eligible for reimbursement. CPT codes 97802 and 97803 are time-based codes for medical nutrition therapies specific for dietician services.

- CPT code 97802 is for initial assessment “each 15 minutes.” This code is to be used only once a year for initial assessment of a new patient.
- CPT code 97803 is for reassessment “each 15 minutes.” This code should also be used when there is a change in the patient's medical condition that affects the patient’s nutritional status.
- CPT code 97804 is for group Therapy (2 or more)/each 30 minutes. This code should be used for all group visits, initial and subsequent.

Restrictions on these codes include the following:

- The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease (Medicare has specific definitions of these conditions).
- The number of hours covered in an episode of care may not be exceeded.
- When follow-up Diabetes Self-Management Training (DSMT) and Medical Nutrition (MNT) services are provided within the same time period, hours from both benefits are counted toward the maximum number of covered hours allowed during the episode of care.

- Dietitians also provide MNT services. If their services are documented properly, they provided the time they spent with the patient in their note, and have a UPIN, it is appropriate to use these codes. Include the appropriate Telemedicine modifier to identify that these services were via video hook-up.

For more information on coding for diabetes education please visit the CMS web site at <http://www.cms.hhs.gov/transmittals/downloads/R13BP.pdf>.

To learn more about the American Diabetes Association's (ADA) recognized Diabetes Treatment Centers and to view the ADA statement regarding tele-education, please visit their web site at <http://www.diabetes.org/for-health-professionals-and-scientists/recognition/edrecognition.jsp>.

2) Remote Non Face-to-Face Services

Services delivered using telecommunications technology, but not requiring the patient to be present during their implementation are covered the same as services delivered when on-site at the medical facility. Remote non face-to-face services are not considered "Telemedicine" by CMS. Rather, they are considered the same as services delivered on-site and are to be coded and paid in the same way. There are no geographic or facility limitations on these services.

3) Home Health Care

Effective October 2000, Medicare commenced payment for home health services pursuant to the Prospective Payment System (PPS), which provides a fixed payment for each Medicare beneficiary for a 60-day period based on the assigned Home Health Resource Group (HHRG). PPS creates an incentive for home health providers to proactively manage delivery of care and to use innovative means of delivering that care while reducing costs. Home health care providers which have costs lower than Medicare payment rates are entitled to retain the difference as a "profit".

To find additional information about Medicare Telemedicine/eHealth services, please see Chapter 15 of the Medicare Benefit Policy Manual (Pub. 100-2) and Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) at <http://www.cms.hhs.gov/manuals/> on the CMS web site.

FEDERALLY QUALIFIED HEALTH CENTERS

Federally Qualified Health Centers (FQHCs) include all organizations receiving grants under section 330 of the Public Health Service Act, certain tribal organizations, and FQHC look-a-likes. FQHC look-a-likes are federally qualified health centers certified as meeting 330 requirements, but are not receiving grant funds. FQHCs are "safety net" providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC program is to enhance the provision of primary care services in underserved urban and rural communities. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. Medicare pays FQHCs at an all-inclusive per visit amount based on reasonable costs with the exception of all therapeutic services provided by clinical and social workers and clinical psychologists, which are subject to the outpatient psychiatric services limitation. This limit does not apply to diagnostic services. Medicare also pays Rural Health Clinics (RHC) on the same basis.

An entity may qualify as an FQHC if it is:

- Receiving a grant under Section 330 of the Public Health Service (PHS) Act;
- Receiving funding from such grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act;
- Determined by Secretary of the Department of Health and Human Services to meet the requirements for receiving such a grant based on the recommendation of the Health Resources and Services Administration; or
- An outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

FQHC Reimbursement Procedures
<p>Billing Between FQHC and Specialty Care Center (such as a university-based hospital): The FQHC bills for a comprehensive/one-day visit rate and the specialty care center bills using a telemedicine modifier (GT or GQ). This allows the insurance company to know that the encounter was via telemedicine and to reimburse the two locations at their full reimbursement rate. This also allows for the patient to pay only one co-payment.</p>
<p>Billing for Telemedicine Services Between FQHC and Another FQHC: For Medi-Cal patients, each FQHC must bill under their own Medi-Cal provider number. In the case of private insurance, both sites must receive authorization in order to be reimbursed.</p>
<p>Billing for Store-and-Forward Consultations <i>Example Situation – A specialist providing store-and-forward consultations</i> A diabetic patient goes to a FQHC facility for his/her annual physical. The FQHC bills Medi-Cal for this service at the normal FQHC rate. The patient is then referred by the general practitioner to have his/her annual ophthalmology exam to screen for diabetic retinopathy, which will be provided through store-and-forward telemedicine by an ophthalmologist at a remote site. The ophthalmologist/specialist who provides the care from the remote site bills at the normal Medi-Cal rate.</p>

MEDICAID/MEDI-CAL

Medicaid, a joint federal/state funded program for low-income Americans, is another source of reimbursement for Telemedicine encounters. Medicaid reimbursement is administered by each state, and policies regarding coverage vary significantly. Medi-Cal is California’s Medicaid health care program. This program pays for a variety of medical services for children and adults with limited income and resources. Medi-Cal is supported by federal and state taxes. Anyone residing in California can apply for Medi-Cal benefits regardless of sex, race, religion, color, national origin, sexual orientation, marital status, age, disability, or veteran status.

People in many different situations may qualify for Medi-Cal. They are listed below.

Some may automatically be eligible for Medi-Cal; they include people who receive cash assistance under one of the following programs:

- **SSI/SSP** (Supplemental Security Income/State Supplemental Program)
- **CalWORKs** (California Work Opportunity and Responsibility to Kids). Previously called Aid to Families with Dependent Children (AFDC).
- **Refugee Assistance**
- **Foster Care or Adoption Assistance Program.**

Californians may also be eligible for Medi-Cal if they are one of the following:

- 65 or older
- Blind
- Disabled
- Under 21
- Pregnant
- Diagnosed with breast or cervical cancer
- In a skilled nursing or intermediate care facility.
- Refugee status during a limited period of eligibility. Adult refugees may or may not be eligible depending upon how long they have been in the U.S.
- Parent or caretaker relative of a child under 21 and
 - The child's parent is deceased or doesn't live with the child, **or**
 - The child's parent is incapacitated, **or**
 - The child's parent who is the primary wage earner is unemployed or underemployed.

In September 2005, legislation was passed in California which now allows for Medi-Cal to cover store-and-forward teledermatology and teleophthalmology services in addition to real-time interactive audio, video or data communications. The telecommunications system used must be of sufficient quality to meet the particular requirements of the level of service.⁹

Location

Unlike Medicare, there is no specific requirement under Medi-Cal that the Telemedicine service be provided in a rural or rural underserved area. The patient site is only a billable visit if it meets all the requirements of the Medi-Cal program. A Telemedicine consult in which there is no presenting provider present during the consult is not eligible for reimbursement of the patient site service – **Medi-Cal does not authorize a facility fee reimbursement for the patient site.**

Medi-Cal does require that there be a barrier to receiving the service face-to-face from the provider. Barriers may be geographic such as unavailable transportation or no local providers willing to accept Medi-Cal.

Provider Type

There is no specific limitation on provider type. The consult site practitioner rendering service must be licensed in the state where he or she performs the service. An understood requirement is that service rendered is within the scope of practice of the practitioner.

CPT CODES

Services	CPT Codes
Psychiatric diagnostic interview examination and psychiatric therapeutic services	90801, 90802, 90804 - 90819, 90821 - 90824, 90826 - 90829, 90853, HCPCS Z0300
Evaluation and management services:	
Office or other outpatient visit (new or established patient)	99201 - 99215
Initial hospital care or subsequent hospital care (new or established patient)	99221 - 99233
Consultations: Office or other outpatient, initial or follow-up inpatient, and confirmatory	99241 - 99255

In addition to the previous codes, other codes as discussed below are being used when appropriate.

Scoping Procedures

- 92504 Binocular Microscopy
- 92511 Nasopharyngoscopy
- 31575 Fiberoptic Laryngoscopy
- 31213 Nasal Endoscopy, Unilateral/Bilateral

The medical peripherals for these procedures (Nasopharyngoscope, flexsigmodoscope, otoscope, slit lamp imager, fundus scope, etc) must be at the patient site.

These diagnostic or treatment services are billed separately from the comprehensive otorhinolaryngologic evaluation; in other words, they are billed as secondary CPT codes. Because these procedures are done at the same time as the consultation and are billed as secondary CPT codes, no GT modifier is required by Medi-Cal, just the barrier explanation in Box 19 of the CMS-1500 billing form.

Nutrition Counseling

Medi-Cal covers nutrition counseling based upon diabetes or other medical conditions while other third party payers may cover these services as obesity-related conditions. Effective January 1, 2006, HCPCS codes G0270, 97802 and 97803 are eligible for reimbursement. CPT

codes 97802 and 97803 are time-based codes for medical nutrition therapies specific for dietician services.

- CPT code 97802 is for the initial assessment “each 15 minutes.” This code is to be used only once a year for initial assessment of a new patient.
- CPT code 97803 is for reassessment “each 15 minutes.” This code should also be used when there is a change in the patient's medical condition that affects the patient’s nutritional status.
- CPT code 97804 is for group Therapy (2 or more)/each 30 minutes. This code should be used for all group visits, initial and subsequent.

Restrictions on these codes include the following:

- The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease.
- The number of hours covered in an episode of care may not be exceeded.
- When follow-up Diabetes Self-Management Training (DSMT) and Medical Nutrition (MNT) services are provided within the same time period, hours from both benefits are counted toward the maximum number of covered hours allowed during the episode of care.
- Dietitians also provide MNT services. If their services are documented properly, they provided the time they spent with the patient in their note and have a UPIN, it would be appropriate to use these codes. Include the “GT” Telemedicine modifier to identify that these services were via video hook-up.

Billing and Reimbursement

Patient Site – Originating Site Facility Fee

If the practitioner at the patient site must participate because of medical necessity, the normal billing and reimbursement is appropriate. Otherwise, there is no patient site reimbursement.

Consult Site

The consult site bills the appropriate codes with the modifier “GT” and receives the normal Medi-Cal reimbursement for the service. In addition, the consult site must indicate in Box 19 of the CMS-1500 the reason the geographic or other barrier the patient faced.

Examples of entries for Box 19 in the Medi-Cal billing manuals include:

- Local provider unavailable
- Local provider wait time unacceptable
- Local provider unwilling to accept Medi-Cal
- Local provider unable to address lingual or cultural needs of patient
- Transportation unavailable
- Time off work for travel creates a financial or personal hardship

Some consult sites report they are using wording such as “Telemedicine – geographic barrier” or “Telemedicine – travel issue” in Box 19 and their claims are approved for payment.

Psychiatrists are allowed to bill and receive reimbursement for Telemedicine services directly from Medi-Cal instead of through the County Mental Health Services agency.

Store-and-Forward Reimbursement for Teleophthalmology and Teledermatology

Teleophthalmology and teledermatology by store-and-forward is defined as an asynchronous transmission of medical information to be reviewed at a later time at a distant site by a physician who is trained in ophthalmology or dermatology, where the physician at the distant site reviews the medical information without the patient being present in real-time.

Effective for dates of service on or after July 1, 2006, “store-and-forward technology” is reimbursable when used for the following teleophthalmology and teledermatology services:

CPT - 4 Codes	Description
99211 – 99214	Office or other outpatient visit
99231 – 99233	Subsequent hospital care
99241 – 99243	Office consultation, new or established patient
99251 – 99253	Initial inpatient consultation

Medi-Cal continues to pay clinics for retinal photography with interpretation (CPT 92250) for services provided by optometrists or ophthalmologists whether performed on-site or remotely. An additional reimbursement for consultation via store-and-forward telemedicine is now payable by Medi-Cal to ophthalmologists. The additional consultation can be billed only if done by an ophthalmologist, not an optometrist.

Providers billing for teleophthalmology or teledermatology with store-and-forward technology must use modifier “GQ” (service rendered by store-and-forward telecommunications system). Only services rendered from the distant site are billed with modifier “GQ.” The use of the modifier does not alter reimbursement.

Store-and-forward teleophthalmology and teledermatology services must meet the following requirements:

- Images must be specific to the patient’s condition and adequate for meeting the definition of the CPT-4 code billed.
- Store-and-forward teleophthalmology and teledermatology must be rendered by a physician who completed training in an Accreditation Council for Graduate Medical Education (ACGME) – approved residency in ophthalmology or dermatology, respectively.

- A patient receiving teleophthalmology or teledermatology by store-and-forward shall be notified of the right to receive interactive communication with the distant specialist physician consulted through store-and-forward, upon request. If requested, communication with the distant specialist physician must occur within 30 days of the patient's notification of the results of the consultation.
- The provider shall comply with the informed consent provision of the Business and Professions Code, Section 2290.5, subdivisions (c) through (g), and subdivisions (i) and (j).
- Teleophthalmology and teledermatology do not include single-mode consultations by telephone calls, images transmitted via facsimile machines or electronic mail.
- Providers are not required to document medical necessity or cost effectiveness to be reimbursed for telemedicine services. However, providers must indicate the barrier to face-to-face visit in the remarks area of the claim, or on an attachment. Examples of barriers include, but are not limited to:
 - Local provider unavailable
 - Local provider wait time unacceptable
 - Local provider unwilling to accept Medi-Cal
 - Local provider unable to address lingual or cultural needs of patient
 - Transportation unavailable
 - Time off work for travel creates a financial or personal hardship

Ophthalmology and dermatology services provided at the originating site at the time of a store-and-forward telemedicine transaction should continue to be billed without a "GQ" modifier.

The updated information on store-and-forward reimbursement is reflected on manual replacement pages medne tel 2, 3 and 7 (Part 2) and modif app4 (Part 2).

COMPARISON OF MEDICARE AND MEDI-CAL REIMBURSEMENT

Requirement	Medicare	Medi-Cal
Telecommunications	Real Time Store and forward allowed only in demonstration sites in Alaska or Hawaii	Real Time Store-and-Forward (only for teleophthalmology and dermatology)
Location	Rural county or rural HPSA	Not restricted, but there must be a barrier to receiving service
Provider Type	Patient site must be physician or other specific provider office, a CAH, RHC, FQHC, or hospital	No restrictions
CPT Codes		
90801	Yes	Yes
90802	No	Yes
90804-90809	Yes	Yes
90810-90819	No	Yes
90821-90824	No	Yes
90826-90829	No	Yes
90853	No	Yes
90862	Yes	No
99201-99215	Yes	Yes
99221-99233	No	Yes
99241-99255	Yes	Yes
HCPCS Z0300	No	Yes
Billing and Payment		
Patient Site	Bills HCPCS code Q3014 and receives flat rate, \$21.86	No payment for patient site unless it is medically necessary for presenting provider to be present.
Consult Site	Uses GT modifier and receives usual Medicare payment	Uses GT or GQ modifier and receives usual Medi-Cal payment. Also, must indicate barrier that prompted use of Telemedicine.

HEALTHY FAMILIES

The Healthy Families Program offers a low cost insurance for children and teens. It provides health, dental, and vision coverage to children who do not have insurance and do not qualify for free Medi-Cal. Families pay a monthly premium of \$4 to \$15 per child with a maximum of \$45 for all children in the family.

Children eligible for Healthy Families must live in California and:

- Be age 18 or younger
- Not be eligible for no-cost Medi-Cal
- Live in families with incomes not higher than 250% of Federal Income Guidelines
- Live in families without health insurance from an employer for the past three months
- Meet citizenship or immigration requirements

The Health Families Program is administered by the Managed Risk Medical Insurance Board (MRMIB). Information about the Health Families Program can be found on the MRMIB web site at www.mmib.ca.gov or the Healthy Families web site at www.healthyfamilies.ca.gov.

CALIFORNIA CHILDREN'S SERVICES (CCS)

California Children's Services (CCS) is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Services manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with state, county and federal tax monies, along with some fees paid by parents.

The program is open to anyone who:

- Is under 21 years old;
- Has or may have a medical condition that is covered by CCS;
- Is a resident of California; and
- Has a family income of \$40,000 or less as reported as the adjusted gross income on the state tax form; or
- The out-of-pocket medical expenses for a child who qualifies are expected to be more than 20 percent of family income; or
- The child has Healthy Families coverage.

CCS follows Medi-Cal policies and procedures concerning coverage and reimbursement of Telemedicine services.¹⁰ You must receive authorization from the CCS program for Telemedicine services in the same situations and process as for non-Telemedicine services.

Location

There is no specific requirement that the Telemedicine service be provided in a rural or rural underserved area. The patient site is only a billable visit if it meets all the requirements of the CCS program. A Telemedicine consult in which there is no presenting provider present during the consult is not eligible for reimbursement of the patient site service – CCS does not authorize a facility fee reimbursement for the patient site.

CCS does require that there be a barrier to receiving the service face to face from the provider. Barriers may be geographic such as transportation unavailable or local providers unwilling to accept CCS patients.

Provider Type

There is no specific limitation on provider type. The consult site practitioner rendering service must be licensed in the state where he or she performs the service. An understood requirement is that service rendered is within the scope of practice of the practitioner.

CPT Codes

Services	CPT Codes
Psychiatric diagnostic interview examination and psychiatric therapeutic services	90801, 90802, 90804 – 90819, 90821 – 90824, 90826 – 90829, 90853, HCPCS Z0300
Evaluation and management services: visits and consultations	
Office or other outpatient visit (new or established patient)	99201 – 99215
Initial hospital care or subsequent hospital care (new or established patient)	99221 – 99233
Consultations: Office or other outpatient, initial or follow-up inpatient, and confirmatory	99241 – 99255

In addition to the above codes, other codes as discussed below are being used when appropriate.

Scoping Procedures

- 92504 Binocular Microscopy
- 92511 Nasopharyngoscopy
- 31575 Fiberoptic Laryngoscopy
- 31213 Nasal Endoscopy, Unilateral/Bilateral

The medical peripherals for these procedures (nasopharyngoscope, flexsigmodoscope, otoscope, slit lamp imager, fundus scope, etc) must be at the patient site.

These diagnostic or treatment services are billed separately from the comprehensive otorhinolaryngologic evaluation; in other words, they are billed as secondary CPT code.

Because these procedures are done at the same time as the consultation and are billed as secondary CPT code, no GT modifier is required by, just the barrier explanation in Box 19 of the CMS-1500 billing form.

Nutrition Counseling

CCS covers nutrition counseling based upon diabetes or other medical conditions while other third party payers may cover these services as obesity-related conditions. Effective January 1, 2006, HCPCS codes G0270, 97802 and 97803 are eligible for reimbursement. CPT codes 97802 and 97803 are time-based codes for medical nutrition therapies specific for dietician services.

- CPT code 97802 is for the initial assessment “each 15 minutes.” This code is to be used only once a year for initial assessment of a new patient.
- CPT code 97803 is for reassessment “each 15 minutes.” This code should also be used when there is a change in the patient's medical condition that affects the patient’s nutritional status.
- CPT code 97804 is for group Therapy (2 or more)/each 30 minutes. This code should be used for all group visits, initial and subsequent.

Restrictions on these codes include the following:

- The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease (Medicare has specific definitions of these conditions).
- The number of hours covered in an episode of care may not be exceeded.
- When follow up Diabetes Self-Management Training (DSMT) and Medical Nutrition (MNT) services are provided within the same time period, hours from both benefits are counted toward the maximum number of covered hours allowed during the episode of care.
- Dieticians also provide MNT services. If their services are documented properly, they provided the time they spent with the patient in their note, and have a UPIN, it is appropriate to use these codes. Include the appropriate Telemedicine modifier to identify that these services were via video hook-up.

Billing and Reimbursement

Patient Site – Originating Site Facility Fee

If the practitioner at the patient site must participate because of medical necessity, the normal billing and reimbursement is appropriate. There is no patient site reimbursement otherwise.

Consult Site

The consult site bills the evaluation and management codes with the modifier “GT” and receives the normal CCS reimbursement for the service. In addition, the consult provider must indicate in Box 19 of the CMS-1500 the geographic or other barrier the patient faced.

The Medi-Cal billing manual includes the following examples of entries for Box 19:

- Local provider unavailable
- Local provider wait time unacceptable
- Local provider unwilling to accept Medi-Cal
- Local provider unable to address lingual or cultural needs of patient
- Transportation unavailable
- Time off work for travel creates a financial or personal hardship

Since CCS follows the same billing requirements as Medi-Cal, these entries are applicable to CCS patients as well.

Some consult sites report they are using wording such as “Telemedicine – geographic barrier” or “Telemedicine – travel issue” in Box 19 and their claims are approved for payment.

COUNTY MEDICAL SERVICES PROGRAM (CMSP)

The County Medical Services Program (CMSP) provides health coverage for low-income, indigent adults in thirty-four, primarily rural California counties. The CMSP Governing Board, established by California law in 1995, is charged with overall program and fiscal responsibility for the program.

This program is open to individuals ages 21 through 64 who reside in a participating county, have incomes at or below 200% of the federal poverty level, and who are not eligible for Medi-Cal benefits.

Effective October 1, 2005, Blue Cross Life & Health assumes responsibility for CMSP medical, dental, and vision benefit administration. Further information on benefit administration is available at the Blue Cross web site at <http://www.bluecrossca.com/>.

BLUE CROSS OF CALIFORNIA—CALPERS, CMSP, HEALTHY FAMILIES AND MEDI-CAL PROGRAMS¹¹

Overview

The following has been designed to give providers detailed information regarding the submission of claims for Telemedicine office visits/consultation services that are rendered to members of CalPERS Basic Plan, CMSP, Healthy Families or Medi-Cal Programs.

For detailed information regarding member enrollment, marketing and member disenrollment please refer to the appropriate Blue Cross CalPERS Basic Plan, CMSP, Healthy Families and/or Medi-Cal program guides.

In order to facilitate timely claims processing and payment, Blue Cross of California requires that standardized billing procedures be followed when submitting claims.

The provider shall bill using the appropriate forms and in a manner acceptable to Blue Cross within the filing limit specified in the provider’s contract. Claims will be processed within thirty (30) working days of receipt of the claim, provided the claim is complete containing all of the required elements outlined for submission of the CMS-1500 or UB-92, or Blue Cross will send a written explanation to the provider stating the reason for the delay.

Electronic Professional Billing

Claims may be submitted electronically through your current electronic billing system. If you are not currently submitting your claims electronically and wish to do so, please call the Electronic Data Interchange (EDI) at Blue Cross of California at 1-800-227-3983.

CALPERS BASIC PLAN TELEMEDICINE BILLING

Modifiers

Blue Cross of California, on behalf of BC Life & Health Insurance Company, administers claims for the CalPERS, PERSCare Basic, and PERS Choice Basic Plan members. Payment of claims is issued by the California State Controller’s Office. Processing Telemedicine claims for CalPERS Basic Plan members is the same as processing standard office visit claims except a Telemedicine modifier must be added to the CPT code: “GT” for Live Video, “GQ” for Store and Forward.

Live Video Telemedicine Encounter

Modifier	Service Type
GT	Live Video Telemedicine encounter for CalPERS Basic Plan members

Store and Forward Telemedicine Encounter

Modifier	Service Type
GQ	Store and Forward Telemedicine encounter for CalPERS Basic Plan members

Form Location for Modifiers

Non-hospital billing entities:

Use Billing form CMS 1500, Box 24D.

Hospital and clinic (FQHC, RHC, IHP) billing entities:

Use billing form UB92, using Box 44.

Additional UB-92 Requirements

Two codes must be used on the UB-92 claim form to identify a clinical Telemedicine encounter:

Type of bill: 130 (enter in UB-92, box 4)

Revenue code: 780 (enter in UB-92, box 42)

Refer to the end of this section to see a sample and instructions for the [UB-92 claim form](#) and [CMS-1500 claim form](#) for Telemedicine.

Billable Codes for Telemedicine

Please call the CalPERS Basic Plan Customer Care Center if you have questions about covered benefits at **1-877-737-7776**.

Claim forms must be coded using the following codes:

Billable Codes for Live Video Telemedicine Encounters

Telecommunication Charges

Blue Cross will pay claims for Blue Cross members’ telecommunication charges for Live Video Telemedicine encounters only. A Live Video encounter requires using high-speed ISDN telecommunications lines, which are more expensive than a regular, long-distance call.

Only the site that initiates the Live Video Telemedicine encounter may bill code 99199-GT.

- Indicate the start and stop time (Box 19 of the CMS-1500, Box 43 of the UB-92) of each Live Video Telemedicine encounter on the claim.
- Bill number of units (Box 24G of the CMS-1500, Box 46 of the UB-92).
- Each minute (or part thereof) is equal to one (1) unit of occurrence.
- A maximum of 90 minutes of occurrence may be billed per Live Video Telemedicine encounter (1.5 hours billable maximum).

Billable CPT Codes for Live Video Telemedicine Encounters

Primary Care Providers	
99201- 99205	New patient office visit
99211- 99215	Established patient office visit
Specialists	
99241- 99245	Consultations

99211- 99215	Follow-up visits
Psychiatry	
90810- 90815	Individual psychotherapy
90816- 90819	Individual psychotherapy (inpt)
90821- 90829	Individual psychotherapy (inpt)
90853	Medical psychoanalysis
90862	Pharmacological psychiatric mgt.
99241- 99245	Consultations
99211- 99215	Established member office visit

Site Fees

Billing entities serving CalPERS Basic Plan members may also charge a Telemedicine Site Fee and should indicate the billing code in Box 24D of the CMS-1500 or Box 44 of the UB-92.

Live Video	Site Fee Billing Code	
	CMS-1500	UB-92
Presentation Site	Q3014	Q3014 Rev Code 780 Bill type 130
Specialty Location	G9002	G9002

Billable Codes for Store and Forward Telemedicine Encounters

Telecommunication Charges

Store and Forward is accomplished via secured email communication. As such, there are no telecommunication charges applicable. Therefore, there is no telecommunication reimbursement offered by Blue Cross.

Primary Care Providers

The preparation of the Store and Forward consult should be billed as part of the primary care provider’s office visit. Use the appropriate CPT code based on total amount of time necessary to complete the office visit and the Store and Forward consultation preparation.

Specialists

Blue Cross will pay claims for the review of patient files for a Store and Forward consult under code:

99241 – 99245 Consultations

Site Fees

Billing entities serving CalPERS Basic Plan members may also charge a Telemedicine Site Fee and should indicate the billing code in Box 24D of the CMS-1500 or Box 44 of the UB-92.

Store and Forward	Site Fee Billing Code	
	CMS-1500	UB-92
Presentation Site	Q3014	Q3014 Rev Code 780 Bill type 130
Specialty Location	Not covered	Not covered

Where to Submit Telemedicine Claims

Submit claims electronically through your clearinghouse or mail all hard copy claims to the address listed on the member’s ID card.

COUNTY MEDICAL SERVICES PROGRAM (CMSP) TELEMEDICINE BILLING

Modifiers

Telemedicine should not be offered to CMSP members who have not yet met their Share of Cost.

Processing Telemedicine claims for CMSP members is the same as processing standard office visit claims except a Telemedicine modifier must be added to the CPT code: “GT” for Live Video, “GQ” for Store and Forward.

Live Video Telemedicine Encounter

Modifier	Service Type
GT	Live Video Telemedicine encounter for CMSP program members

Store and Forward Telemedicine Encounter

Modifier	Service Type
GQ	Store and Forward Telemedicine encounter for CMSP program members

Form Location for Modifiers

Non-hospital billing entities:

Use billing form CMS 1500, Box 24D

Hospital and clinic (FQHC, RHC, IHP) billing entities:

Use billing form UB92, using Box 44.

Additional UB-92 Requirements

Two codes must be used on the UB-92 claim form to identify a clinical Telemedicine encounter:

Type of bill: 130 (enter in UB-92, box 4)
 Revenue code: 780 (enter in UB-92, box 42)

Refer to the end of this section to see a sample and instructions for the [UB-92 claim form](#) and [CMS-1500 claim form](#) for Telemedicine.

Billable Codes for Telemedicine

Please call the CMSP Customer Care Center if you have questions about covered benefits at 1-800-670-6133.

Claim forms must be coded using the following codes:

Billable Codes for Live Video Telemedicine Encounters

Telecommunication Charges

Blue Cross will pay claims for Blue Cross members’ telecommunication charges for Live Video Telemedicine encounters only. A Live Video encounter requires using high-speed ISDN telecommunications lines, which are more expensive than a regular, long-distance call.

Only the site that initiates the Live Video Telemedicine encounter may bill code T1014.

- Indicate the start and stop time (Box 19 of the CMS-1500, Box 43 of the UB-92) of each Live Video Telemedicine encounter on the claim.
- Bill number of units (Box 24G of the CMS-1500, Box 46 of the UB-92).
- Each minute (or part thereof) is equal to one (1) unit of occurrence.
- A maximum of 90 minutes of occurrence may be billed per Live Video Telemedicine encounter (1.5 hours billable maximum).

Billable CPT Codes for Live Video Telemedicine Encounters

Primary Care Providers	
99201-99205	New patient office visit
99211-99215	Established patient office visit
Specialists	
99241-99245	Consultations
99211-99215	Follow-up visits
Psychiatry	
90801-90809	Psychiatric diagnosis
90810-90815	Individual psychotherapy
90816-90819	Individual psychotherapy (inpt)
90821-90829	Individual psychotherapy (inpt)
90853	Medical psychoanalysis
90862	Pharmacological psychiatric mgt.
99241-99245	Consultations
99211-99215	Established member office visit

Billable Codes for Store and Forward Telemedicine Encounters

Telecommunication Charges

Store and Forward is accomplished via secured email communication. As such, there are no

telecommunication charges applicable. Therefore, there is no telecommunication reimbursement offered by Blue Cross.

Primary Care Providers

The preparation of the Store and Forward consult should be billed as part of the primary care provider’s office visit. Use the appropriate CPT code based on total amount of time necessary to complete the office visit and the Store and Forward consultation preparation.

Specialists

Blue Cross will pay claims for the review of patient files for a Store and Forward consult under code:

99241 – 99245 Consultations

Where to Submit Telemedicine Claims

Submit claims electronically through your clearinghouse or mail all hard copy claims to the address listed on the member’s ID card.

BLUE CROSS OF CALIFORNIA HEALTHY FAMILIES BILLING

Modifiers

Processing Telemedicine claims for Healthy Families members is the same as processing standard office visit claims except a Telemedicine modifier must be added to the CPT code: “GT” for Live Video, “GQ” for Store and Forward.

Live Video Telemedicine Encounter

Modifier	Service Type
GT	Live Video Telemedicine encounter for BCC Healthy Families members

Store and Forward Telemedicine Encounter

Modifier	Service Type
GQ	Store and Forward Telemedicine encounter for BCC Healthy Families members

Form Location for Modifiers

Non-hospital billing entities:

Use Billing form CMS 1500, Box 24D.

Hospital and clinic (FQHC, RHC, IHP) billing entities:

Use billing form UB92, using Box 44.

Additional UB-92 Requirements

Two codes must be used on the UB-92 claim form to identify a clinical Telemedicine encounter:
 Type of bill: 130 (enter in UB-92, box 4)
 Revenue code: 780 (enter in UB-92, box 42)

Refer to the end of this section to see a sample and instructions for the [UB-92 claim form](#) and [CMS-1500 claim form](#) for Telemedicine.

Billable Codes for Telemedicine

Please call the Healthy Families Customer Care Center if you have questions about covered benefits at 1-800-845-3604.

Claim forms must be coded using the following codes:

Billable Codes for Live Video Consults

Telecommunication Charges

Blue Cross will pay claims for Blue Cross members’ telecommunication charges for Live Video Consultations only. A Live Video Consult requires using high-speed ISDN telecommunications lines, which are more expensive than a regular, long-distance call.

Only the site that initiates the Live Video Telemedicine encounter may bill code T1014.

- Indicate the start and stop time (Box 19 of the CMS-1500, Box 43 of the UB-92) of each Live Video Telemedicine encounter on the claim.
- Bill number of units (Box 24G of the CMS-1500, Box 46 of the UB-92).
- Each minute (or part thereof) is equal to one (1) unit of occurrence.
- A maximum of 90 minutes of occurrence may be billed per Live Video Telemedicine encounter (1.5 hours billable maximum).

Billable CPT Codes for Live Video Telemedicine Encounters

Primary Care Providers	
99201-99205	New patient office visit
99211-99215	Established patient office visit
Specialists	
99241-99245	Consultations
99211-99215	Follow-up visits
Psychiatry	
90801-90809	Psychiatric diagnosis
90810-90815	Individual psychotherapy
90816-90819	Individual psychotherapy (inpt)
90821-90829	Individual psychotherapy (inpt)
90853	Medical psychoanalysis
90862	Pharmacological psychiatric mgt.
99241-99245	Consultations
99211-99215	Established member office visit

Site Fees

Billing entities serving Healthy Families members may also charge a Telemedicine Site Fee and should indicate the billing code in Box 24D of the CMS-1500 or Box 44 of the UB-92.

Live Video	Site Fee Billing Code	
	CMS-1500	UB-92
Presentation Site	Q3014	Q3014 Rev Code 780 Bill type 130
Specialty Location	G9002	G9002

Billable Codes for Store and Forward Consultations

Telecommunication Charges

Store and Forward is accomplished via secured email communication. As such, there are no telecommunication charges applicable. Therefore, there is no telecommunication reimbursement offered by Blue Cross.

Primary Care Providers

The preparation of the Store and Forward consult should be billed as part of the primary care provider’s office visit. Use the appropriate CPT code based on total amount of time necessary to complete the office visit and the Store and Forward consultation preparation.

Specialists

Blue Cross will pay claims for the review of patient files for a Store and Forward consult under code:

99241 – 99245 Consultations

Site Fees

Billing entities serving Healthy Families members may also charge a Telemedicine Site Fee and should indicate the billing code in Box 24D of the CMS-1500 or Box 44 of the UB-92.

Store and Forward	Site Fee Billing Code	
	CMS-1500	UB-92
Presentation Site	Q3014	Q3014 Rev Code 780 Bill type 130
Specialty Location	Not covered	Not covered

Where to Submit Telemedicine Claims

Submit claims electronically through your clearinghouse or mail all hard copy claims to the address listed on the member’s ID card.

BLUE CROSS OF CALIFORNIA PARTNERSHIP PLAN MEDI-CAL BILLING

Modifiers

Processing Telemedicine claims for Medi-Cal members is the same as processing standard office visit claims except a Telemedicine modifier must be added to the CPT code: “GT” for Live Video, “GQ” for Store and Forward.

Live Video Telemedicine Encounter

Modifier	Service Type
GT	Live Video Telemedicine encounter for BCC Partnership Plan Medi-Cal program members

Store and Forward Telemedicine Encounter

Modifier	Service Type
GQ	Store and Forward Telemedicine encounter for BCC Partnership Plan Medi-Cal program members

Form Location for Modifiers

Non-hospital billing entities:

Use Billing form CMS 1500, Box 24D.

Hospital and clinic (FQHC, RHC, IHP) billing entities:

Use billing form UB92, using Box 44.

Additional UB-92 Requirements

Two codes must be used on the UB-92 claim form to identify a clinical Telemedicine encounter:

Type of bill:	130 (enter in UB-92, box 4)
Revenue code:	780 (enter in UB-92, box 42)

Refer to the end of this section to see a sample and instructions for the [UB-92 claim form](#) and [CMS-1500 claim form](#) for Telemedicine.

Billable Codes for Telemedicine

Please call the BCC Partnership Plan Customer Care Center if you have questions about covered benefits for Medi-Cal (all counties except LA) at **1-800-407-4627**. For Los Angeles County please call **1-888-285-7801**.

Claim forms must be coded using the following codes:

Billable Codes for Live Video Telemedicine Encounters

Telecommunication Charges

Blue Cross will pay claims for Blue Cross members’ telecommunication charges for Live Video

Telemedicine encounter only. A Live Video encounter requires using high-speed ISDN telecommunications lines, which are more expensive than a regular, long-distance call.

Only the site that initiates the Live Video Telemedicine encounter may bill code T1014.

- Indicate the start and stop time (Box 19 of the CMS-1500, Box 43 of the UB-92) of each Live Video Telemedicine encounter on the claim.
- Bill number of units (Box 24G of the CMS-1500, Box 46 of the UB-92).
- Each minute (or part thereof) is equal to one (1) unit of occurrence.
- A maximum of 90 minutes of occurrence may be billed per Live Video Telemedicine encounter (1.5 hours billable maximum).

Billable CPT Codes for Live Video Telemedicine Encounters

Primary Care Providers	
99201-99205	New patient office visit
99211-99215	Established patient office visit
Specialists	
99241-99245	Consultations
99211-99215	Follow-up visits
Psychiatry	
Z0300	Individual psychotherapy
90801-90809	Psychiatric diagnosis
90810-90815	Individual psychotherapy
90816-90819	Individual psychotherapy (inpt)
90821-90829	Individual psychotherapy (inpt)
90853	Medical psychoanalysis
90862	Pharmacological psychiatric mgt.
99241-99245	Consultations
99211-99215	Established member office visit

Site Fees

Billing entities serving Medi-Cal members may also charge a Telemedicine Site Fee and should indicate the billing code in Box 24D of the CMS-1500 or Box 44 of the UB-92.

Live Video	Site Fee Billing Code	
	CMS-1500	UB-92
Presentation Site	Q3014	Q3014 Rev Code 780 Bill type 130
Specialty Location	G9002	G9002

Billable Codes for Store and Forward Telemedicine Encounters

Telecommunication Charges

Store and forward is accomplished via secured email communication. As such, there are no telecommunication charges applicable. Therefore, there is no telecommunication reimbursement offered by Blue Cross.

Primary Care Providers

The preparation of the Store and Forward consult should be billed as part of the primary care provider’s office visit. Use the appropriate CPT code based on total amount of time necessary to complete the office visit and the Store and Forward consultation preparation.

Specialists

Blue Cross will pay claims for the review of patient files for a Store and Forward consult under code:

99241 - 99245 Consultations

Site Fees

Billing entities serving Medi-Cal members may also charge a Telemedicine Site Fee and should indicate the billing code in Box 24D of the CMS-1500 or Box 44 of the UB-92.

Store and Forward	Site Fee Billing Code	
	CMS-1500	UB-92
Presentation Site	Q3014	Q3014 Rev Code 780 Bill type 130
Specialty Location	Not covered	Not covered

Where to Submit Telemedicine Claims

Submit claims electronically through your clearinghouse or mail all hard copy claims to the address listed on the member’s ID card.

TELEMEDICINE SAMPLE SECTION FROM CMS-1500 FORM (TOP)

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S ID NUMBER 9 digit certificate number
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient's complete name		3. PATIENT'S BIRTH DATE Date of birth Patient's sex
5. PATIENT'S ADDRESS (No., Street) Patient's street address		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> s Self or child <input checked="" type="checkbox"/> Other <input type="checkbox"/>
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Member's complete name		7. INSURED'S ADDRESS (No., Street) N/A (same as box 5)
CITY City STATE "CA"	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	CITY STATE
ZIP CODE Zip code TELEPHONE (Include Area Code) Patient's phone	Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/>	ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, MI) a. OTH If patient has another coverage, complete boxes 9a-9d.		10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. SIGNER Patient's signature or "Signature on file" Date		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED Patient's signature or "Signature on file"

TELEMEDICINE SAMPLE SECTION FROM THE CMS-1500 FORM (BOTTOM) WITH INSTRUCTIONS

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) Date of onset		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE Date of first consultation		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO MM DD YY MM DD YY								
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Referring Provider		17a. I.D. NUMBER OF REFERRING PHYSICIAN Referring Provider's Number		16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO MM DD YY MM DD YY								
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$CHARGES								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. Primary diagnosis 2. Secondary diagnosis 3. Additional diagnosis 4. _____				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.								
23. PRIOR AUTHORIZATION NUMBER Authorization number/information												
24. A DATE(S) OF SERVICE FROM TO MM DD YY MM DD YY		B Place of Service	C Type of Service	D PROCEDURES, SVCS, OR SUPPLIES Explain unusual circumstances CPT/HCPCS MODIFIER		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
From date/s of service	To date/s of service	Place of service	Type of service	Telemedicine Procedure Codes	Modifier code	Diagnosis cross reference 1 thru 4	Line Total	Unit/s of	Rendering Provider's license number			
25. FEDERAL TAX I.D. NUMBER SSN EIN Provider's Tax ID		26. PATIENT'S ACCOUNT NO. Patient number		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> yes <input type="checkbox"/> no		28. TOTAL CHARGE \$ Claim Total		29. AMOUNT PAID		30. BALANCE DUE Balance due		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to) Signature of provider certifying the claim		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) Location of where services were actually rendered				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE# Provider's name and complete						
(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)		PLEASE PRINT OR TYPE				FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500						

- Enter the appropriate procedure codes for:
- Telecommunication charge
 - Primary Care Providers billing for Live Video Telemedicine Encounter
 - Primary Care providers billing for Store and Forward Telemedicine Encounter
 - Specialists billing for Live Video Telemedicine Encounter
 - Specialists billing for review of Store-and-Forward Consultation

- Enter the appropriate Telemedicine Modifier:
- GT - Live Video Telemedicine Encounter
 - GQ - Store and Forward Telemedicine Encounter

TELEMEDICINE SAMPLE SECTION FROM THE UB-92 FORM WITH INSTRUCTIONS

1 Facility name and Address	2		3. PATIENT CONTROL NO. Patient number			4 TYPE OF BILL															
12 PATIENT NAME Patient's Name	13 PATIENT ADDRESS Patient's Address		5 FED TAX NO	6 STATEMENT FROM	7 D.	8 N-C-D.	9 C-I-D.	10 L-R-D.	Type of bill = 130 for Telemedicine												
14 BIRTHDATE Date of birth	15 SEX Sex	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D. HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31				
32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49				
42 REV CD	43 DESCRIPTION	44 HCPCS/RATES	45 SERV DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON COVERED CHARGES	49	50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56							
57	58 INSURED'S NAME	59 P. REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	67 PRIN.DIAG CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM DIAG CD	77 E-CODE	78
80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	
84 REMARKS	85 PROV	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105

Enter the appropriate Billable Code and Telemedicine Modifier:

- GT - Live Video Telemedicine Encounter
- GQ - Store-and-Forward Telemedicine Encounter

Appendices

APPENDIX A: LISTING OF HPSAS FOR MEDICARE COVERAGE OF TELEMEDICINE

The following table includes a listing of all California counties. Patient sites in counties shown as rural are eligible for Medicare coverage of Telemedicine. If the county is not rural, only patient sites included within that county in a rural HPSA are eligible for coverage.

Rural HPSAs in the table are accurate as of October 2006. Ensure that the designation is current by checking the following website: <http://hpsafind.hrsa.gov/HPSAsearch.aspx>.

Here are the steps to select a HPSA:

- State - "CA",
- County - type in desirable county or counties (separate by comma),
- Discipline - "Primary Medical Care"
- Then click on "Show me the HPSAs" button

The list of HPSAs for the county will include Metropolitan and Non-Metropolitan designations. Also, some HPSAs are for specific facilities and do not include census tract information (those locations are not included in this list). Only the Non-Metropolitan HPSAs with census tracts are covered patient sites for Medicare.

There are some specific facilities that are in urban counties and designated as a HPSA. If you wish to provide Telemedicine services, you should contact your Medicare carrier or fiscal intermediary to ensure that the services will be reimbursed as a patient site.

Urban/Rural/Frontier	HPSA	Census Tracts
Alameda County		
Urban	Hayward Central/San Leandro E. (MSSA 2H)	4091.00, 4092.00, 4093.00, 4094.00, 4323.00, 4326.00, 4331.00, 4332.00, 4337.00, 4339.00, 4340.00, 4354.00, 4356.00, 4357.00, 4663.00, 4366.00, 4374.00, 4375.00, 4377.00, 4378.00, 4379.00, 4380.00, 4381.00, 4382.02, 4402.00, 4403.01
Alpine County		
Rural	None	
Amador County		
Rural	None	
Butte County		

Urban/Rural/Frontier	HPSA	Census Tracts
Frontier	Feather Falls (MSSA 11)	0024.00
Rural	Oroville/Palermo (MSSA 10)	0025.00, 0026.00, 0027.00, 0028.00, 0029.00, 0030.00, 0031.00, 0032.00, 0033.00
Calaveras County		
Rural	None	
Colusa County		
Rural	None	
Del Norte County		
Rural	None	
El Dorado County		
Rural	Pollock Pines (MSSA 23.2)	0313.01, 0313.02, 0314.02, 0314.03, 0314.04, 0314.05, 0314.06
Rural	Low Inc – South Lake Tahoe (MSSA 24)	0301.01, 0301.02, 0302.00, 0303.00, 0304.01, 0304.02, 0305.01, 0305.02, 0305.03
Fresno County		
Rural	Low Inc- Reedley (MSSA 32)	0063.00, 0064.03, 0065.00, 0066.01, 0066.02, 0067.00, 0068.01, 0068.02
Rural	Firebaugh/Mendota (MSSA 25)	0083.01, 0083.02, 0084.01, 0084.02
Rural	San Joaquin-Tranquility (MSSA 26)	0082.00
Rural	Selma (MSSA 30)	0008.00, 0009.00, 0010.00, 0011.00, 0017.00, 0018.00, 0019.00, 0070.02, 0070.03, 0070.04, 0071.00, 0072.01, 0072.02, 0073.00, 0074.00, 0075.00, 0076.00, 0077.00
Rural	Coalinga/Huron (MSSAs 27 & 28)	0078.00, 0079.00, 0080.00, 0081.00
Rural	Herndon/Kerman (MSSA 29)	0038.03, 0039.00, 0040.00, 0041.00, 0042.07

Urban/Rural/Frontier	HPSA	Census Tracts
Rural	Clovis East/Fowler (MSSA 31)	0015.00, 0016.00, 0055.11, 0055.15, 0059.02, 0059.03, 0059.04, 0060.00, 0061.00, 0062.00, 0064.01, 0064.02, 0069.00
Glenn County		
Frontier	Low Inc/MFW – Willows (MSSA 37)	0103.00, 0104.00, 0105.02
Humboldt County		
Rural	Low Inc – Eureka (MSSA 39)	0001.00, 0002.00, 0003.00, 0004.00, 0005.00, 0006.00, 0007.00, 0008.00, 0009.00, 0011.00, 0012.00, 0106.00, 0107.00
Rural	Willow Creek/Hoopa (MSSA 38)	0101.01, 0101.02
Rural	Fortuna (MSSA 42)	01808.00, 0109.00, 0110.00, 0111.00, 0112.00
Frontier	Garberville/Redway (MSSA 44)	0113.00
Rural	Rio Dell/Scotia (MSSA 43)	0111.00
Rural	Low Inc – Mckinleyville (MSSA 40)	0102.00, 0103.00, 0104.00, 0105.01, 0105.02
Imperial County		
Rural	Calexico (MSSA 49)	0119.00, 0120.00, 0121.00, 0122.00
Rural	East Imperial (MSSA 46, 47, & 50)	0101.00, 0102.00, 0103.00, 0104.00, 0105.00, 0106.00, 0107.00, 0123.02, 0124.00, 0125.00
Rural	El Centro (MSSA 48)	0108.00, 0109.00, 0110.00, 0111.00, 0112.01, 0112.02, 0113.00, 0114.00, 0115.00, 0116.00, 0117.00, 0118.01, 0118.02, 0118.03
Inyo County		
Frontier	Big Pine/ Lone Pine/ Tecopa (MSSAs 54, 55, & 56)	0005.00, 0006.00, 0007.00
Rural	Low inc – Bishop (MSSA 53)	0001.00, 0002.00, 0003.00, 0004.00

Urban/Rural/Frontier	HPSA	Census Tracts
Kern County		
Urban	E Bakersfield (MSSA 66B)	0011.01, 0011.02, 0011.03, 0012.00, 0013.00, 0014.00, 0015.00, 0019.01, 0019.02, 0020.00, 0021.00, 0022.00, 0023.01, 0023.02, 0024.00, 0025.00, 0026.00, 0027.00, 0029.00, 0030.00, 0031.03, 0031.13, 0031.21
Rural	Taft (MSSA 57.2)	0033.03, 0033.04, 0034.00, 0035.00, 0036.00
Rural	Boron/ California City (MSSA 65)	0055.03, 0055.04, 0055.05, 0055.06, 0056.00, 0057.00, 0058.00, 0059.00
Rural	Tehachapi (MSSA 62)	0060.01, 0060.02, 0061.00
Rural	Frazier Park (MSSA 57.1)	0033.02
Rural	Lost Hills/Wasco (MSSA 58.2)	0043.01, 0043.02, 0044.01, 0044.02, 0045.00
Rural	Low Inc – Lake Isabella (MSSA 63)	0052.01, 0052.02
Rural	Low Inc/MSFW – Delano / MCFA (MSSA 60)	0046.01, 0047.00, 0047.00, 0048.00, 0049.01, 0049.02, 0050.00
Rural	Buttonwillow (MSSA 59)	0037.00
Rural	Shafter (MSSA 58.1)	0039.00, 0040.00, 0041.01, 0041.02, 0042.00
Rural	Low Inc/MSFW – Arvin/Lamont (MSSA 61)	0062.01, 0062.02, 0063.01, 0063.02, 0064.01, 0064.02
Kings County		
Rural	Avenal (MSSA 67)	0017.01, 0017.02
Rural	Corcoran (MSSA 68)	0013.00, 0014.00, 0015.00, 0016.01, 0016.02
Rural	Low Inc – Hanford/ Lemoore (MSSA 69.2)	0001.00, 0002.00, 0003.00, 0004.02, 0004.03, 0004.04, 0004.05, 0005.00, 0006.01, 0006.02, 0007.01, 0007.02, 0008.00, 0009.00, 0010.01, 0010.02, 0010.03, 0011.00, 0012.00
Lake County		

Urban/Rural/Frontier	HPSA	Census Tracts
Rural	Low Inc – Lakeport/ Up Lake (MSSAs 70.1 & 70.2)	0001.00, 0003.00, 0005.00, 0010.00
Rural	Cobb/ Middletown (MSSA 71.3)	0011.00, 0013.00
Lassen County		
Frontier	Big Valley (MSSA 73)	0401.00
Rural	Low Inc- Susanville (MSSA 72)	0403.01, 0403.02, 0404.00, 0405.00
Frontier	Low Inc – Westwood (MSSA 75)	0402.00
Frontier	Doyle (MSSA 74)	0406.00
Los Angeles County		
Urban	Highland Park (MSSA 78.21)	1831.01, 1831.02, 1832.00, 1833.00, 1835.00, 1836.00, 1837.00, 1838.00, 1991.00, 1992.01, 1993.00, 1998.00, 2011.00, 2012.00, 2013.01, 2013.02, 2014.01, 2014.02, 2015.01, 2015.02, 2016.00, 5307.00
Urban	San Catalina Island (MSSA 78.1)	5990.00, 5991.00
Urban	East Compton (MSSA 78.2BBB)	5415.00, 5416.01, 5416.02, 5420.00, 5421.01, 5421.02, 5422.00, 5424.01, 5424.02, 5425.00, 5426.00, 5427.00, 5432.00
Urban	Pomona Central (MSSA 78.2SS)	4020.00, 4023.01, 4023.02, 4024.01, 4024.02, 4025.01, 4025.02, 4026.00, 4027.01, 4027.02, 4028.00, 4029.01, 4029.02, 4030.00, 4088.00
Urban	Low Inc – Mission Hills/San Fernando	1042.01, 1042.02, 1044.01, 1061.02, 1064.01, 1066.01, 1066.02, 1070.00, 1091.00, 1094.00, 1095.00, 3201.00, 3202.00, 3203.00
Urban	Low Inc – Pacoima/N. Sun Valley (MSSA 78.2 PPP)	1041.01, 1041.02, 1043.00, 1044.02, 1045.00, 1046.00, 1047.01, 1047.02, 1048.00, 1210.00, 1211.00, 1212.00, 1218.00, 1219.00, 1221.00, 1222.00

Urban/Rural/Frontier	HPSA	Census Tracts
Urban	Low Inc – Pico Union/Westlake (MSSA 78.2B)	2083.00, 2084.00, 2085.00, 2086.00, 2087.00, 2088.00, 2089.01, 2089.02, 2091.01, 2091.02, 2092.00, 2093.00, 2094.01, 2094.02, 2094.03, 2095.00, 2098.00, 2100.00, 2111.00, 2112.00, 2113.00, 2119.00, 2121.00, 2122.01, 2122.02, 2123.01, 2134.01, 2134.02, 2211.00, 2242.00, 2243.00, 2244.00
Urban	Li/Homeless – Venice/S. Santa Monica (MSSA 78.2Z)	2722.00, 2723.02, 2732.00, 2733.00, 2734.00, 2735.00, 2736.00, 2737.00, 2738.00, 2751.00, 2752.00, 2755.10, 2755.20, 7018.02, 7019.00, 7020.00, 7021.00, 7022.01, 7022.02, 7028.03
Urban	Low Inc – E. San Pedro (MSSA 78.2P)	2942.00, 2943.00, 2944.00, 2945.00, 2946.00, 2947.00, 2948.00, 2949.00, 2949.99, 2951.00, 2951.99, 2961.00, 2961.00, 2962.00, 2971.00, 2971.99, 5727.00, 5757.99, 2941.00
Rural	Lake Los Angeles (MSSA 77.2)	9001.00, 9002.00, 9003.00
Urban	Low Inc – Van Nuys Central (MSSA 78.2CC)	1233.02, 1234.00, 1235.00, 1236.01, 1236.02, 1237.00, 1238.00, 1271.01, 1271.02, 1272.00, 1273.00, 1274.00, 1276.01, 1276.02, 1277.00, 1278.01, 1278.02, 1279.00, 1281.00, 1282.00, 1283.01
Urban	Low Inc – Exposition PK (MSSA 78.2L)	2216.00, 2217.00, 2218.00, 2219.00, 2226.00, 2227.00, 2246.00, 2247.00, 2267.00, 2284.00, 2311.00, 2312.00, 2313.00, 2314.00, 2315.00, 2316.00, 2317.00,
Urban	Low Inc – S. Central NE (MSSA 78.2GGG)	2283.00, 2285.00, 2286.00, 2292.00, 2293.00, 2294.00, 2319.00, 2321.00, 2327.00, 2328.00, 2371.00, 2374.00, 2375.00, 2376.00, 2392.00, 2393.00

Urban/Rural/Frontier	HPSA	Census Tracts
Urban	Pasadena (MSSA 78.2HHH)	4609.00, 4610.00, 4611.00, 4615.00, 4616.00, 4619.00, 4620.00, 4621.00, 4622.00, 4623.00, 4624.00, 4627.00, 4628.00
Rural	Littlerock (MSSA 77.3)	9100.00, 9109.00, 9110.00
Urban	Watts/Willowbrook (MSSA 78.2AAA)	2408.00, 2409.00, 2410.00, 2420.00, 2421.00, 2422.00, 2423.00, 2426.00, 2427.00, 2430.00, 2431.00, 5352.00, 5404.00, 5406.00, 5407.00, 5408.00, 5412.00, 5413.00, 5414.00
Urban	Florence/Firestone (MSSA 78.2FFF)	2395.00, 2396.00, 2397.00, 2398.00, 2400.00, 2402.00, 2405.00, 2406.00, 2407.00, 5349.00, 5350.00, 5351.01, 5351.02, 5353.00, 5354.00
Urban	West Adams (MSSA 78.2NNN)	2184.00, 2185.00, 2186.00, 2187.00, 2188.00, 2189.00, 2190.00, 2193.00, 2195.00, 2197.00, 2198.00, 2199.00, 2200.00, 2201.00, 2214.00, 2215.00, 2220.00, 2221.00, 2222.00, 2225.00, 2361.00, 2362.01, 2362.02
Urban	Low Inc – S. Central Southwest (MSSA 78)	2377.00, 2378.00, 2380.00, 2382.00, 2383.00, 2384.00, 2403.00, 2404.00, 2411.00, 2412.00, 6001.00, 6002.01, 6002.02, 6003.01, 6003.02, 6004.00
Urban	Low Inc – Baldwin Park (MSSA 78.2YYY)	4047.00, 4048.00, 4049.00, 4050.00, 4051.00, 4052.00, 4065.00, 4067.00, 4068.00, 4069.00, 4070.00, 4071.01, 4071.02, 4074.00, 4083.01
Urban	Bell Southwest/ Vernon (MSSA 78.2DDD)	5324.00, 5333.00, 5334.01, 5334.02, 5334.03, 5335.01, 5335.02, 5335.03, 5336.01, 5336.02, 5336.03, 5338.01, 5338.03, 5338.04, 5343.01, 5343.02, 5344.03, 5344.04, 5344.05, 5344.06

Urban/Rural/Frontier	HPSA	Census Tracts
Urban	City Terrance E./ E. LA (MSSA 78.2D)	5303.01, 5303.02, 5304.00, 5305.00, 5306.01, 5306.02, 5308.02, 5310.00, 5311.02, 5312.01, 5312.02, 5313.01, 5313.02, 5315.01, 5315.02, 5316.02, 5316.03, 5316.04, 5317.01, 5317.02
Madera County		
Rural	Oakhurst (MSSA 79.1)	0001.02, 0001.03, 0001.04, 0001.05
Rural	Madera West/Southwest (MSSA 80)	0004.00, 0005.02, 0005.03, 0005.06, 0005.07, 0005.08, 0005.09, 0006.01, 0006.02, 0007.00, 0008.00, 0009.00, 0010.00
Marin County		
Rural	Bolinas/Stinson Beach (MSSA 81)	1130.00, 1142.00, 1182.00, 1321.00, 1322.00, 1330.00
Mariposa County		
Rural	Bootjack (MSSA 85 & 86)	0001.00, 0002.00, 0003.00, 0004.00
Mendocino County		
Frontier	Covelo (MSSA 92)	0101.00
Frontier	Laytonville/Leggett (MSSA 90)	0102.00
Rural	Low Inc- Boonville (MSSA 87.1)	0112.00
Merced County		
Rural	Low Inc – Los Banos (MSSA 94)	0020.00, 0021.00, 0022.01, 0022.02, 0023.01, 0023.02, 0024.00
Rural	Livingston (MSSA 95)	0001.00, 0002.00, 0003.01, 0003.02, 0004.00, 0005.01, 0005.02, 0006.00, 0007.00, 0008.00, 0301.00
Modoc County		
Frontier	Low Inc – Alturas/Canby (MSSA 98)	0001.00, 0003.00
Frontier	Low Inc – Surprise Valley (MSSA 99)	0004.00

Urban/Rural/Frontier	HPSA	Census Tracts
Frontier	Adin/Lookout (MSSA 100)	0002.00
Mono County		
	None	
Monterey County		
Rural	Gonzales / Greenfield / Soledad (MSSA 107)	0108.98, 0109.00, 0111.00, 0112.00
Rural	Low Inc – MFW – King City (MSSA 105)	0113.00, 0114.02
Napa County		
	None	
Nevada County		
	None	
Orange County		
Urban	Low Inc – Anaheim Central (MSSA 116L)	0018.02, 0116.01, 0116.02, 0117.19, 0117.20, 0865.01, 0865.02, 0866.01, 0866.02, 0867.01, 0867.02, 0871.02, 0871.04, 0872.00, 0873.00, 0874.01, 0874.02, 0874.03, 0875.01
Placer County		
Frontier	Foresthill (MSSA 120)	0202.00
Rural	Colfax (MSSA 118.1)	0219.01, 0219.02, 0220.02
Rural	Kings Beach (MSSA 117)	0201.01, 0201.02, 0201.03, 0201.04, 0201.05, 0201.06, 0201.07, 0220.01
Plumas County		
Frontier	Low Inc – Quincy SA (MSSA 123)	0001.00, 0002.00
Frontier	Low Inc – Chester (MSSA 122/125)	0004.00, 0005.00
Riverside County		
Rural	Low Inc – Mecca SA (MSSA 128)	0456.01, 0456.02
Rural	Idyllwild/Pine Cove (MSSA 130)	0444.01, 0444.02, 0444.03

Urban/Rural/Frontier	HPSA	Census Tracts
Urban	Riverside Downtown (MSSA 135A)	0301.00, 0302.00, 0304.00, 0305.00, 0401.00, 0402.00, 0403.00, 0422.01, 0422.02, 0422.03, 0423.00
Urban	Hemet / San Jacinto (MSSA 132)	0433.01, 0433.02, 0433.03, 0434.01, 0434.02, 0435.01, 0435.02, 0436.00, 0437.00
Sacramento County		
Urban	Fruitridge/Oak Park (MSSA 139F)	0017.00, 0018.00, 0027.00, 0028.00, 0029.00, 0030.00, 0031.01, 0031.02, 0032.01, 0032.02, 0036.00, 0037.00, 0044.01, 0044.02, 0045.00, 0046.01, 0046.02, 0047.00, 0048.01, 0048.02, 0050.01, 0050.02, 0051.01, 0051.02, 0051.03
San Benito County		
Rural	San Benito (MSSA 140)	0001.00, 0002.00, 0003.00, 0004.00, 0005.00, 0006.00, 0007.00, 0008.00
San Bernardino County		
Rural	29 Palms / Yucca Valley (MSSA 144.2 & 144.3)	0104.03, 0104.05, 0104.09, 0104.10, 0104.11, 0104.12, 0104.13, 0104.14, 0104.15, 0104.16
Frontier	Argus/Trona (MSSA 142)	0089.01
Rural	Lake Arrowhead (MSSA 147)	0108.01, 0108.02, 0109.00, 0110.00
Rural	Big Bear Lake (MSSA 146)	0111.00, 0112.01, 0113.00, 0114.00, 0115.00
Urban	South Rialto/Fontana (MSSA 151F)	0025.01, 0025.02, 0026.01, 0031.00, 0032.00, 0033.00, 0034.03, 0036.01, 0036.02, 0040.00, 0050.00, 0060.00, 0066.00, 0067.00, 0068.00, 0069.00, 0070.00
San Diego County		
	Borrego Springs (MSSA 152)	0209.02, 0209.03, 0209.04, 0210.00

Urban/Rural/Frontier	HPSA	Census Tracts
	Mountain Empire	0211.00
Urban	Lemon Grove/National City (MSSA 161G)	0030.01, 0030.03, 0030.04, 0031.01, 0031.11, 0031.12, 0031.13, 0032.02, 0033.01, 0033.02, 0033.03, 0034.03, 0034.04, 0119.02, 0120.01, 0120.02, 0120.03, 0121.02, 0122.00, 0143.00, 0144.00
Urban	City Heights (MSSA 161D)	0014.00, 0015.00, 0022.01, 0022.02, 0023.02, 0024.01, 0024.02, 0025.01, 0025.02, 0026.01, 0026.02, 0027.05, 0027.07, 0027.08, 0027.09, 0027.10, 0034.01, 0042.00, 0043.00, 0044.00
San Francisco County		
Urban	S of Market (MSSA 162C)	0122.00, 0123.00, 0124.00, 0125.00, 0176.02, 0176.98, 0177.00, 0178.00, 0179.01, 0179.02, 0179.99, 0180.00, 0201.98, 0226.00, 0227.00, 0228.00, 0229.00, 0607.00
Urban	Alemany/Excelsior (MSSA 162F)	0230.01, 0230.02, 0230.03, 0231.01, 0231.02, 0231.03, 0232.00, 0233.00, 0234.00, 0251.00, 0252.00, 0254.01, 0254.02, 0254.03, 0256.00, 0257.00, 0258.00, 0259.00, 0260.01, 0260.02, 0260.03, 0260.04, 0263.01, 0263.02, 0263.03, 0264.01, 0264.02, 0264.03, 0264.04, 0605.01, 0605.02, 0606.00, 0609.00, 0610.00
San Joaquin County		

Urban/Rural/Frontier	HPSA	Census Tracts
Urban	French Camp/Stockton South (MSSA 169B)	0001.00, 0003.00, 0004.01, 0004.02, 0005.00, 0006.00, 0007.00, 0008.00, 0009.00, 0016.00, 0017.00, 0018.00, 0019.00, 0020.00, 0021.00, 0022.00, 0024.00, 0025.01, 0025.02, 0027.01, 0027.02, 0028.00, 0036.01, 0036.02, 0037.00, 0038.01, 0038.02, 0038.03
San Luis Obispo County		
Rural	Low Inc – Paso Robles (MSSA 173)	0100.00, 0101.00, 0102.00, 0103.00
Rural	Low Inc/MFW Arroyo Grande (MSSA 171)	0117.00, 0118.00, 0119.00, 0120.00, 0121.00, 0122.00, 0123.00,
Rural	Low Inc/MFW/HMLSS – Atascadero (MSSA 170)	0125.00, 0126.00
San Mateo County		
Urban	E. Menlo Park/ E. Palo Alto	6101.00, 6102.00, 6104.00, 6105.00, 6106.00, 6107.00, 6108.00, 6109.00, 6117.00, 6118.00, 6119.00, 6120.00, 6121.98, 6123.00, 6124.00
Santa Barbara County		
Rural	Guadalupe (MSSA 180.2)	0025.00
Rural	Low Inc – Lompoc (MSSA 179)	0026.03, 0026.04, 0027.02, 0027.03, 0027.05, 0027.06, 0027.07, 0027.08, 0028.02, 0028.05, 0028.06, 0028.07, 0028.08, 0028.09
Santa Clara County		
Rural	Gilroy/Morgan Hill (MSSA 182)	5122.00, 5123.04, 5123.05, 5123.06, 5123.07, 5123.08, 5123.09, 5124.01, 5124.02, 5125.03, 5125.05, 5125.06, 5125.07, 5125.08, 5126.01, 5126.02, 5127.00
Santa Cruz County		

Urban/Rural/Frontier	HPSA	Census Tracts
Urban	L I/MFW-Freedom/Watsonville (MSSA 184)	1101.00, 1102.00, 1103.00, 1104.00, 1105.00, 1105.01, 1105.02, 1106.00, 1107.00
Shasta County		
Rural	Central Shasta (MSSA 188)	0126.00
Frontier	Lakehead (MSSA 187)	0125.00
Rural	Low Inc – Anderson / Cottonwood (MSSA 186)	0120.00, 0121.00, 0122.00, 0123.01, 0123.02, 0123.03, 0124.00
Frontier	Burney (MSSA 190)	0127.00
Sierra County		
Frontier	None	
Siskiyou County		
Frontier	Happy Camp (MSSA 193)	0005.00
Frontier	Etna/Fort Jones (MSSA 194)	0006.00, 0008.00
Frontier	Butte Valley/ Dorris (MSSA 200)	0002.00
Frontier	Tulelake (MSSA 196)	0001.00
Frontier	Mc Cloud/Tennant (MSSA 199)	0012.00
Rural	Low Inc- Gazelle/Grenada (MSSA 195)	0003.00, 0004.00, 0007.01, 0007.02, 0007.03
Solano County		
	None	
Sonoma County		
Rural	Cloverdale (MSSA 206)	1541.00, 1542.00
Rural	Sonoma Valley (MSSA 208)	1501.00, 1502.01, 1502.02, 1503.02, 1503.03, 1503.04, 1505.00, 1506.06
Stanislaus County		
Urban	LI/MFW-Denair/Turlock (MSSA 212.1)	0036.02, 0036.04, 0038.01, 0038.02, 0038.03, 0039.04, 0039.05, 0039.06, 0039.07, 0039.08, 0039.09

Urban/Rural/Frontier	HPSA	Census Tracts
Rural	Low Inc- Oakdale (MSSA 211)	0001.01, 0001.02, 0002.01, 0002.02, 0002.03, 0003.01, 0003.02, 0003.03, 0003.04, 0004.02
Urban	Ceres/Modesto S. Cen (MSSA 215C)	0016.01, 0016.03, 0016.04, 0017.00, 0018.00, 0019.00, 0021.00, 0022.00, 0023.01, 0023.02, 0024.00, 0025.01, 0025.02, 0026.03, 0026.04, 0027.01, 0027.02
Rural	Low Inc – Newman/Patterson (MSSA 213)	0032.01, 0032.02, 0033.00, 0034.00, 0035.00
Sutter County		
Rural	Low Inc – Yuba City (MSSA 216)	0501.01, 0501.02, 0502.01, 0502.02, 0503.01, 0503.02, 0504.00, 0505.01, 0505.03, 0505.04, 0506.01, 0506.03, 0506.04, 0508.00, 0509.00, 0510.00
Tehama County		
Rural	Low Inc- Red Bluff (MSSA 221)	0002.00, 0004.00, 0005.00, 0006.00, 0007.00, 0008.00
Rural	Corning (MSSA 222)	0009.00, 0010.00, 0011.00
Trinity County		
Frontier	Junction City/Weaverville (MSSA 223 & 224)	0001.00, 0002.00
Frontier	Mad River (MSSA 226)	0004.00
Frontier	Hayfork (MSSA 225)	0003.00
Tulare County		
Rural	Porterville/Springville (MSSA 231)	0034.00, 0035.00, 0036.00, 0037.00, 0038.01, 0038.02, 0039.01, 0039.02, 0040.00, 0041.01, 0041.02, 0042.00, 0043.00, 0044.00, 0045.00
Rural	Lindsay (MSSA 228.2)	0014.00, 0015.01, 0015.02, 0025.00, 0026.01, 0026.02, 0028.00, 0033.00
Rural	Dinaba [sic] / Orosi / Cutler (MSSA 227)	0002.00, 0003.02, 0003.98, 0004.00, 0005.00, 0006.00

Urban/Rural/Frontier	HPSA	Census Tracts
Rural	Low inc- Tulare/Tipton (MSSA 230)	0021.00, 0022.01, 0022.02, 0023.02, 0023.03, 0023.04, 0024.00, 0029.01, 0029.03, 0029.04, 0030.01, 0030.02, 0031.00, 0032.00
Tuolumne County		
Frontier	Chinese Camp/ Groveland (MSSAs 234.1 & 235)	0042.00, 0052.01, 0052.02
Ventura County		
Urban	Oxnard West / Ventura South (MSSA 241C) (S)	0024.00, 0025.00, 0026.00, 0027.00, 0028.01, 0028.02, 0029.00, 0033.00, 0036.03, 0036.04, 0036.05, 0036.06, 0042.00, 0043.01, 0043.02
Rural	Low Inc – Santa Paula (MSSA 237)	0001.00, 0002.00, 0003.00, 0004.00, 0005.00, 0006.00, 0007.00, 0008.00
Urban	Low Inc – Oxnard N. Central (MSSA 241B)	0030.01, 0030.02, 0031.00, 0032.00, 0033.00, 0034.01, 0034.02, 0035.00, 0037.00, 0038.00, 0039.00, 0041.00, 0045.01, 0049.00, 0050.01, 0050.02
Yolo County		
	None	
Yuba County		
	None	

APPENDIX B: LISTING OF CPT CODES BY PAYER

CPT Code	Medicare	Medi-Cal/ CMSP/CCS	Blue Cross of CA – Healthy Families and Medi-Cal
31213	Yes	Yes	No
31575	Yes	Yes	No
90801	Yes	Yes	Yes
90802	No	Yes	Yes
90804-90809	Yes	Yes	Yes
90810-90819	No	Yes	Yes
90821-90824	No	Yes	Yes
90826-90829	No	Yes	Yes
90845-90849	No	No	Yes
90853	No	Yes	Yes
90857	No	No	Yes
90862	Yes	No	Yes
90865-90880	No	No	Yes
90899	No	No	Yes
92504	Yes	Yes	No
92511	Yes	Yes	No
96100	No	No	Yes
96117	No	No	Yes
97802-97804	Yes	Yes	No
99201-99215	Yes	Yes	Yes
99221-99233	No	Yes	No
99241-99245	Yes	Yes	Yes
99251-99255	Yes	Yes	No
99261-99263	No	No	Yes
99271-99275	No	No	No
G0270	Yes	Yes	No
G0308-G0309	Yes	No	No

CPT Code	Medicare	Medi-Cal/ CMSP/CCS	Blue Cross of CA – Healthy Families and Medi-Cal
G0311- G0312	Yes	No	No
G0314-G0315	Yes	No	No
G0317-G0318	Yes	No	No
HCPCS Z0300	No	Yes	No

Glossary of Terms

Benefits Improvement and Protection Act (BIPA)

The federal Benefits Improvement and Protection Act of 2000 significantly changed the Telemedicine services covered by Medicare.

Critical Access Hospital (CAH)

Critical Access Hospital, a Medicare designation of a hospital that is limited in size and scope of services.

California Children's Services (CCS)

California children's Services is a program that treats children with certain physical limitations and chronic health conditions or diseases.

County Medical Services Program (CMSP)

County Medical Services Program covers health care services for certain low-income populations in small, rural counties.

Current Procedural Terminology (CPT)

Current Procedural Terminology is a coding set used by providers and payers.

Distant Site

The site where the physician or practitioner providing the professional service is located at the time the service is provided via Telemedicine.

DSMT

Acronym commonly used for Diabetes Self-Management Training

eHealth

The provision of healthcare supported by electronic processes and communication. eHealth is an overarching term that could include real-time videoconferencing, store-and-forward applications, electronic health records, remote disease monitoring, and many other modalities.

Federally Qualified Health Center (FQHC)

Federally Qualified Health Center is a federal designation for a facility providing primary care and other services to underserved populations.

GQ

Store-and-Forward Telemedicine billing procedure modifier.

GT

Real-time/interactive Telemedicine billing procedure modifier.

Health Common Procedure Coding System (HCPCS)

The HCPCS provides additional codes that are used along with CPT codes.

Healthy Families

Healthy Families is California's low cost health insurance for children and teens. It is a federal/state program.

Health Professional Shortage Area (HPSA)

Health Professional Shortage Area as designated by the federal Health Resources and Services Administration.

Medi-Cal

California's version of Medicaid. Medicaid is a federal/state program covering health services to certain low-income groups.

Medicare

Federal program covering health services to the elderly and disabled.

MNT

Acronym commonly used for Medical Nutrition.

Metropolitan Statistical Area (MSA)

Used by Medicare to identify an urban county. All counties that are not MSA's are considered rural.

Originating Site

The location of an eligible beneficiary at the time the service being furnished via Telemedicine occurs.

Originating Site Facility Fee

The payment amount for eligible originating site which presents the patient.

Professional Fee

The payment amount for the professional service provided via Telemedicine.

Real-Time

In Telemedicine terms, conducting an encounter or consultation where both parties are available and interacting simultaneously. Real-time Telemedicine is generally conducted via full motion videoconferencing.

Rural Health Clinic (RHC)

A federal designation for a facility located in a rural area and providing primary care services.

Store-and-Forward

A Telemedicine encounter or consult that relies on the asynchronous transfer of still digital images of a patient, or clinical data, such as blood glucose levels or electrocardiogram measurements, from one site to another for the purpose of rendering a medical opinion or diagnosis. Common types of store-and-forward services include radiology, pathology, dermatology, ophthalmology, and wound care.

Telemedicine

The use of telecommunications and information technologies for the provision of healthcare at a distance. New methods continue to evolve over time, but this includes real-time videoconferencing as well as store-and-forward methodologies.

Unique Physician Identification Number (UPIN)

The UPIN is used for billing. Certain non-physician providers also are assigned UPIN numbers.

References

- ¹ *Consent Law Manual*, 31st Edition, published by the California Hospital Association 2004.
- ² American Telemedicine Association (2006). Medicare payment of telemedicine and telehealth services. Retrieved July 18, 2006 from <http://www.atmeda.org/news/library.htm>.
- ³ *American Telemedicine Association Report on Reimbursement*, April, 2003, Washington, D.C.
- ⁴ Puskin, Dena S. (September 30, 2001) "Telemedicine: Follow the Money" *Online Journal of Issues in Nursing*. Vol. #6 No. #3, Manuscript 1.
- ⁵ *Medicare Intermediary Manual* (CMS Publication 13-3), Baltimore, Maryland, Centers for Medicare and Medicaid Services.
- ⁶ *Medicare Benefit Policy* (CMS Publication 100-02), Internet publication only, Baltimore, Maryland, Centers for Medicare and Medicaid Services.
- ⁷ *Medicare Claims Processing Manual* (CMS Publication 100-04), Internet publication only, Baltimore, Maryland, Centers for Medicare and Medicaid Services.
- ⁸ *CMS Carriers Manual*, Part 3 Chapter XV Fee Schedule for Physicians' Service, Part 15516.
- ⁹ *Inpatient/Outpatient Provider Manual*, Department of Health Services, Medi-Cal Program, Internet version, Sacramento, California.
- ¹⁰ May 18, 2004 letter from Marian Dalsey, M.D., M.P.H., Acting Chief, Children's Medical Services Branch, California Department of Health Services.
- ¹¹ Blue Cross of California, *Blue Cross of California Telemedicine Program for Health Families and Medi-Cal Program – Telemedicine Billing Guidelines*, no date or place of publication listed.