TELEMEDICINE: DEVELOPMENTS, TRENDS AND LEGAL RISKS©

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OVERVIEW:

In the most recent projection, from 2007 to 2017, CMS expects U.S. health care spending to almost double from roughly $2.2 trillion to $4.3 trillion, while the share of GDP devoted to health care is expected to grow from 16.3 percent to 19.3 percent.[1]

The Washington Post on December 2, 2008, reported that the newest predictions are the Medicare program will be essentially bankrupt by 2019.

Presumed Secretary-designate of the Department of Health and Human Services, Tom Daschle has stated: the United States is "years if not decades behind European nations in harnessing healthcare information technology's potential". [Daschle, T., Critical: What we can do about the Health Care Crisis.]

I. New Telemedicine Developments and Trends

A. New Developments in Telemedicine/Telehealth

1. The electronic health record as a predicate.

The work of the VHA and Dept of Defense is the US best practice to date. At the end of November 2008 the Defense Department and VHA announced they had completed the Bidirectional Health Information Exchange, an initiative which permits DOD and VA health clinicians to view health information in the other's system in real time and exchange same. VHA has extensive telehealth systems,chronic disease management capability and outcomes.

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[1] Keehan S, Sisko A, Truffer C, Smith S, Cowan C, Poisal J, Clemens MK. "Health Spending Projections Through 2017: The Baby-Boom Generation is Coming to Medicare." Health Affairs, Web Exclusive, February 26, 2008.

2. The European efforts to fund ambient health care

   The Ambient Assisted Living (AAL) joint national programme funded by the European Union will cover market-oriented R&D on concrete ICT-based solutions for ageing well with a time to market of 2-3 years, in particular with focus on involvement of small and medium sized enterprises [called "SMEs"]. The AAL aligns with the information and computer technology efforts work plan focusing on longer term research topics for ICT concepts over 5-10 years' time.

3. The United Kingdom major pilots on deployed remote monitoring for chronic disease management are in the "Whole System Demonstrator". Northern Ireland's country-wide pilot also is underway. Developments, for example:

   UK: Newham—2 year research project; 2000 persons with chronic illnesses such as heart failure, chronic obstructive pulmonary disease [COPD] and diabetes using telecare and telehealth equipment in their homes. Coordination between health and "social" needs.
   http://www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_4140328

4. Devices as diagnosis- enhancers: Examples: Wearable health monitoring devices permitting instantaneous adjustments to health regimes or decisional actions on emergent events. Intel's new remote monitoring system; Phillips; HoneywellHomed; Bosch..

5. The privatization of the effort to reach common standards and efforts to advance health IT. The emergence of "AHIC Successor". For information, *see* the weblink at:
   www.ahicsuccessor.org/hhs/ahic.nsf/index.htm

6. Coverage and access to physicians: real-time and to address emergent issues: Example: From NightHawk to WebMD model to SwiftMD.

   SwiftMed, a New York based company, according to its press release "delivers a phone or bi-directional Internet video consultation with a [board- certified] emergency medicine physician within approximately 30 minutes of a member's initial request. There is a one-time registration fee for the set-up of a member's secure and HIPAA compliant personal health record (PHR), a monthly membership fee and a consultation fee for each

SwiftMD visit. SwiftMD doctors interact with members by phone or Internet, review members' PHRs and diagnose non-critical illnesses or conditions. Physicians can prescribe and refill medications and order lab tests when necessary. Physicians can also facilitate follow-up care with an ER, specialist or primary care physicians. "

B. Legislation Introduced in the 2008 Congressional Session:

1. The **Telehealth for America Act of 2008** (S. 3491);

2. The **Broadband Data Improvement Act** (S. 1492);

3. The **Independent at Home Act of 2008** (S. 3613);

4. Senator Max Baucus's Health Reform Proposals: http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf

C. Technology- Enabled Care: Telemedicine, Remote Monitoring and Telehealth

1. Health care services from a satellite health facility

2. Health care services in situ with telemedicine devices

3. Remote monitoring and sensors

a. Safety

b. Health and wellness

c. Social connectedness

4. Awareness and Acceptance: AARP Study of telehealth/telemedicine: "Healthy@Home", March 2008 www.aarp.org/research/housing-mobility/indliving/healthy_home

II. Telehealth ---Governmental and Industry Reimbursement & Impediments:

A. Reimbursement

There is much talk about electronic health records [EHRs] and connectivity within systems [electronic bedside to health record connectivity] but little action, in even the broadest areas, to include

reimbursement. When we talk about patient care, we need a multi-prong model for the future.
At present, Telemedicine is limited in Medicare –Attachment A, Benefits Manual.

1. Medicare only pays for telemedicine in rural or resource-limited geographic settings.

2. Medicare does not pay for store-and-forward telemedicine.

3. Medicare does not pay all on-physician practitioners, generally.

4. Medicare is now going to pay for new origination sites, including SNF rural health sites, mental health centers and renal dialysis centers. Discussion of Section 149 of MIPPA and subsequent regulations at 73 Federal Register 69726, beginning at 69879-881 (November 19,2008). http://edocket.access.gpo.gov/2008/pdf/E8-26213

5. Medicare does not pay for home-based ***telehealth*** costs for equipment, therapists or nurses, and interactions are not "visits" for PPS-counting purposes.

B. Medicaid payment for telehealth is limited. *See*, Office for the Advancement of Telehealth, HRSA, Department of Health and Human Services 2003 Report.

C. Grants

1. Grants from the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA)'s Office of Rural Health Policy and Office for the Advancement of Telehealth [OAT] can be mired in Congressional Budget issues.

   a. HRSA plans to award $4.5 million in technology grants to up to 60 rural healthcare facilities in 2008-9 up to $75,000 in annual funding but rural public or rural non-profit private healthcare provider and not a previous grant recipient or be a faith-based or community-based organization. Grants will be awarded on Sept. 1, 2008. *See* http://ruralhealth.hrsa.gov/funding/SHCPQI.asp

   b. OAT has issued numerous grants in telemedicine; four of which are home-based telehealth for chronic disease outcomes measurement.

c. Recent HRSA grant example: A $227,613 federal grant was provided in December 2008 by HRSA to the Office of Telemedicine at the University of Virginia for deployment in Southwest Virginia remote sites. (Office of US Rep. Rick Boucher)

2. Grants from FCC to States for a $400 Million Rural Health Care Pilot Program (RHCPP) to create broadband infrastructure to support electronic health records for 42 states and territories and approximately 6,000 care sites.[November 2007]

3. State Grants, such as the New York State HEAL Grants

Recent announcements include multi-million dollar grants to several collaboratives, *e.g.* Maimonides Medical Center/ Brooklyn Health Information Exchange (BHIE)	NYC - 1199 SEIU; Elderplan; First to Care Homecare; Kingsbrook Jewish; Metropolitan Jewish Geriatric Center Nursing Home; Rutland Nursing Home; Shorefront Jewish Geriatric Center and Home Care; Sephardic Skilled Nursing and Rehabilitation Center; Visiting Nurse Service of New York.	$4,048,266	Create electronic data exchange among participating organizations with focus on disease management across the continuum of care for persons with complex, chronic diseases.	Walter Fahey Phone: 718-283-1895 E-mail: wfahey@maimonidesmed.org

4. US Dept of Agriculture - $15 million in new grants in November 2008.

The Distance Learning and Telemedicine (DLT) program:health care needs of rural America.--Eastern Maine Healthcare System $800,000 loan and a $200,000 grant to allow shared records in 18 locations. Kossuth Regional Health Center, in Iowa receives a $537,532 loan and a $134,382 grant to enhance electronic medical record filing and transmission speeds.

5. Contracts between Providers and Insurers

Recent Example: Aetna and ZixCorp's agreement makes over 1,000 primary care physicians in northern New Jersey eligible to receive, at no charge, an e-prescribing device and associated connectivity services. E-prescribing devices provide physicians with access to health plan formulary and drug interaction information, and electronically submit prescriptions to the patient's preferred pharmacy, helping to reduce prescribing errors, and saving members the time of having to drop off hand-written prescriptions at the pharmacy. Approximately 40,000 members of Aetna's plan would benefit. The contract follows pilot programs in New Jersey, New York and Connecticut.

D. Outcomes, Cost savings, and Disease Management Concerns

1. CMS has taken a position that disease management for chronic disease processes has not to date had sufficient research support from the cost savings or quality outcomes standpoint. Rand conference in Washington, DC Winter 2008 and announcement of the end of Phase One of Medicare demonstration on support for chronic disease.

2. Significant numbers of telehealth projects in USA and in Western Europe have already or are showing promise with regard to avoided hospitalizations, improved outcomes, and patient and physicians satisfaction. *See* presentation summaries from 2008 American Telemedicine Association Annual meeting at www.americantelemed.org.

3. Some health system- sponsored research programs are concentrating on demonstrating outcomes. See: Partners HealthCare, Center for Connected Health. http://www.connected-health.org/.

E. Telemedicine/Telehealth---Licensure Impediments

1. *See*: Office for the Advancement of Telemedicine, HRSA, Department of Health and Human Services, Telemedicine Licensure Report, 2003, and American Telemedicine Association website www.americantelemed.org.

2. Often barriers are requirements for a physical examination of a patient by the health practitioner, the existence of a physician-patient relationship prior to prescribing drugs or medical devices, the necessity that the performing physician create an H&P [history and physical] for the record prior to diagnosis, etc.

3. States may establish "limited licenses" for telemedicine which prevents the professional from also coming instate to practice.

4. Penalties are severe and may include the unlicensed practice of medicine as a criminal action at or above the misdemeanor level.

5. Some jurisdictions considering a separate licensure status for the entity itself, as a telehealth provider.

6. European Union has researched inter-country impediments: "Legally eHealth".

F. Telehealth---Medical Devices, and Medical Device Law Impediments

1. Device Interconnectivity is a problem. Continua Health Alliance, a consortium of medical device manufacturers & software companies, is working on common standards, based on available criteria [Bluetooth, IEEE ,etc.]

2. Software in Medical Devices—FDA regulatory hurdles; 510K process.

3. Consumer Protection concepts are in flux.

G. Fraud and Abuse Laws – Scrutiny of physicians and kickbacks

1. Physicians continue to be a key focus of health care fraud enforcement efforts according to Health and Human Services Office of Inspector General Chief Counsel Lewis Morris. [Comments from ABA conference November 2008].

2. OIG "Safe harbor" for Certain Electronic Prescribing and Health Records Arrangements, 8/8/2006 71 Fed. Reg. 45110, amending 42 CFR § 1001.952. [Materials supplied with this outline.]

III. What needs to be done to improve care for the Boomers?

"Respondents named strengthening the primary care system (90%), encouraging care coordination (90%) and promoting care management of high-cost patients with complex conditions (88%) as important policy strategies in improving health care delivery. Support for these strategies was strong across sectors. For business leaders, encouraging care coordination (90%) and promoting care management of complex patients (90%) were important policy approaches. Health care delivery leaders said strengthening primary care (94%) and encouraging care coordination (94%) were important".[2]

"Older adults and their friends and family have a large role to play. Patients can retain their independence by learning how to manage their health, particularly chronic diseases. Training programs should be set up to help family members, friends, and others get the knowledge and skills they need to provide care to their loved ones and to alleviate the stress they may feel from providing this care."[3]

National Health Quality Priorities Initiative: White Paper
http://www.nationalprioritiespartnership.org/uploadedFiles/NPP/NPP%20PRESS%20RELEASE%20final%20formatted3.pdf

IV. Ability of Elderly to Access Health IT= Major Papers

A. USA – *See*: http://www.ahrq.gov/clinic/tp/hitbartp.htm

B. EU ---November 2008 Communique: "Telemedicine for the Benefit of Patient, Health Care Systems and Society" http://ec.europa.eu/information_society/activities/health/policy/telemedicine/index_en.htm.

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[2] The Commonwealth Fund, Commission on High Performance Health System-Health Care Opinion Leaders' Views on Health Care Delivery System Reform, Data Brief, April 2008, pg 4.
[3] "Retooling for an Aging America: Rebuilding the Health Care Workforce", Institute of Medicine Report, April 14, 2008, Summary sheet.

ATTACHMENT A

MEDICARE BENEFITS MANUAL IOM 100-2, Chap 15.207

270 - Telehealth Services
(Rev. 31, Issued: 04-01-05; Effective: 01-01-05; Implementation: 05-02-05)

Background

Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) - Revision of Medicare Reimbursement for Telehealth Services amended §1834 of the Act to provide for an expansion of Medicare payment for telehealth services.

Effective October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system. Eligible geographic areas include rural health professional shortage areas and counties not classified as a metropolitan statistical area (MSA). Additionally, Federal telemedicine demonstration projects as of December 31, 2000, may serve as the originating site regardless of geographic location.

An interactive telecommunications system is required as a condition of payment; however, BIPA does allow the use of asynchronous "store and forward" technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. BIPA does not require that a practitioner present the patient for interactive telehealth services.

With regard to payment amount, BIPA specified that payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at time of telemedicine encounter) is equal to what would have been paid without the use of telemedicine. Distant site practitioners include only a physician as described in §1861(r) of the Act and a medical practitioner as described in §1842(b)(18)(C) of the Act. BIPA also expanded payment under Medicare to include a $20 originating site facility fee (location of beneficiary).

Previously, the Balanced Budget Act of 1997 (BBA) limited the scope of Medicare telehealth coverage to consultation services and the implementing regulation prohibited the use of an asynchronous 'store and forward' telecommunications system. The BBA of 1997 also required the professional fee to be shared between the referring and consulting practitioners, and prohibited Medicare payment for facility fees and line charges associated with the telemedicine encounter.

The BIPA required that Medicare Part B (Supplementary Medical Insurance) pay for this expansion of telehealth services beginning with services furnished on October 1, 2001.

Time limit for teleconsultation provision

The teleconsultation provision as authorized by §4206 (a) and (b) of the BBA of 1997 and implemented in 42 CFR 410.78 and 414.65 applies only to teleconsultations provided on or after January 1, 1999, and before October 1, 2001.

270.1 - Eligibility Criteria
(Rev. 1, 10-01-03)

Furnished by CMS
Beneficiaries are eligible for telehealth services **only** if they are presented from an originating site located either in a rural HPSA or in a county outside of a MSA.

Entities participating in a Federal telemedicine demonstration project that were approved by or were receiving funding from the Secretary of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location. Such entities are not required to be in a rural HPSA or non-MSA.

An originating site is the location of an eligible Medicare beneficiary at the time the service being furnished via telecommunications system occurs. Originating sites authorized by law are listed below.

The office of a physician or practitioner.

A hospital.

A critical access hospital.

A rural health clinic.

A federally qualified health center.

270.2 – List of Medicare Telehealth Services
(Rev. 74, Issued: 06-29-07, Effective: 01-01-08, Implementation: 01-07-08)
Furnished by CMS

The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultations, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, end stage renal disease related services, and individual medical nutrition therapy. These services and corresponding current procedure terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes are listed below.

Consultations (CPT codes 99241 - 99275) (Effective October 1, 2001 – December 31, 2005).

Consultations (CPT codes 99241 – 99255) (Effective January 1, 2006)
.
Office or other outpatient visits (CPT codes 99201 - 99215).

Individual psychotherapy (CPT codes 90804 - 90809).

Pharmacologic management (CPT code 90862).

Psychiatric diagnostic interview examination (CPT code 90801) (Effective March 1, 2003).

End stage renal disease related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318). (Effective January 1, 2005).

Individual Medical Nutrition Therapy (HCPCS codes G0270, 97802, and 97803) (Effective January 1, 2006).

Neurobehavioral status exam (CPT code 96116) (Effective January 1, 2008).

270.3 – Conditions of Payment
(Rev. 1, 10-01-03)
Furnished by CMS

For Medicare payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.

Exception to the Interactive Telecommunications Requirement

In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, Medicare payment is permitted for telemedicine when asynchronous "store and forward technology," in single or multimedia formats, is used as a substitute for an interactive telecommunications system. The originating site and distant site practitioner must be included within the definition of the demonstration program.
For the purposes of this instruction, store and forward means the asynchronous transmission of medical information to be reviewed at a later time by a physician or practitioner at the distant site. A patient's medical information may include but not limited to, video clips, still images, x-rays, MRIs, EKGs and EEGs, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time.

NOTE: Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients' condition and adequate for rendering or confirming a diagnosis or a treatment plan. Dermatological photographs, e.g., photographs of a skin lesion, may be considered to meet the requirement of a single media format under this instruction.

Telepresenters: A medical professional is not required to present the beneficiary to the physician or practitioner at the distant site unless medically necessary. The decision of medical necessity will be made by the physician or practitioner located at the distant site.

270.4 – Payment – Physician/Practitioner at a Distant Site
(Rev. 43, Issued: 12-23-05; Effective: 01-01-06; Implementation: 04-03-06)
Furnished by CMS

The term "distant site" means the site where the physician or practitioner providing the professional service is located at the time the service is provided via a telecommunications system.

The payment amount for the professional service provided via a telecommunications system by the physician or practitioner at the distant site is equal to the current fee schedule amount for the service provided. Payment for telehealth services (*see* §270.2) should be made at the same amount as when these services are furnished without the use of a telecommunications system. For Medicare payment to occur, the service must be within a practitioner's scope of practice under State law. The beneficiary is responsible for any unmet deductible amount and applicable coinsurance.

Medicare Practitioners Who May Receive Payment at the Distant Site (i.e., at a Site Other Than Where a Beneficiary Is)

As a condition of Medicare Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under State law.

When the physician or practitioner at the distant site is licensed under State law to provide a covered telehealth service (*see* §270.2) then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

Medicare practitioners who may bill for a covered telehealth service are listed below (subject to State law):

Physician;

Nurse practitioner;

Physician assistant;

Nurse midwife;

Clinical nurse specialist;

Clinical psychologist;

Clinical social worker; and

Registered dietitian or nutrition professional.

* 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.

270.4.1 – Payment for ESRD-Related Services as a Telehealth Service
(Rev. 31, Issued: 04-01-05; Effective: 01-01-05; Implementation: 05-02-05)

The ESRD-related services included in the monthly capitation payment (MCP) with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month may be paid as Medicare telehealth services. However, at least 1 visit must be furnished face-to face“ hands on” to examine the vascular access site by a physician, clinical nurse specialist, nurse practitioner, or physicians assistant.

An interactive audio and video telecommunications system may be used for providing additional visits required under the 2-to-3 visit MCP and the 4-or-more visit MCP. The medical record must indicate that at least one of the visits was furnished face-to-face “hands on” by a physician, clinical nurse specialist, nurse practitioner, or physician assistant.

The MCP physician, for example, the physician or practitioner who is responsible for the complete monthly assessment of the patient and establishes the patient’s plan of care, may use other physicians and practitioners to furnish ESRD-related visits through an interactive audio and video telecommunications system. The non-MCP physician or practitioner must have a relationship with the billing physician or practitioner such as a partner, employees of the same group practice or an employee of the MCP physician, for example, the non MCP physician or practitioner is either a W-2 employee or 1099 independent contractor. However, the physician or practitioner who is responsible for the complete monthly assessment and establishes the ESRD beneficiary’s plan of care should bill for the MCP in any given month.

Clinical Criteria

The visit including a clinical examination of the vascular access site must be conducted face-to-face “hands on” by a physician, clinical nurse specialist, nurse practitioner or physician’s assistant. For additional visits, the physician or practitioner at the distant site

is required, at a minimum, to use an interactive audio and video telecommunications system that allows the physician or practitioner to provide medical management services for a maintenance dialysis beneficiary. For example, an ESRD-related visit conducted via telecommunications system must permit the physician or practitioner at the distant site to perform an assessment of whether the dialysis is working effectively and whether the patient is tolerating the procedure well (physiologically and psychologically). During this assessment, the physician or practitioner at the distant site must be able to determine whether alteration in any aspect of the beneficiary's prescription is indicated, due to such changes as the estimate of the patient's dry weight.

Clarification on originating sites

Medicare telehealth originating sites only include a physician's or practitioner's office, hospital, critical access hospital, rural health clinic, or Federally-qualified health center. ESRD facilities are not originating sites (dialysis facilities are not defined in the law as an originate site). ESRD-related visits may be furnished through an interactive telecommunications system (other than the required visit to examine the vascular access site) when the beneficiary is located in an originating site as defined in §270.1, including a physician's satellite office within a dialysis center.

270.5 - Originating Site Facility Fee Payment Methodology
(Rev. 1, 10-01-03)
Furnished by CMS

The term originating site means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii. For telehealth services (*see* §270.2) furnished from October 1, 2001, through December 31, 2002, the originating site fee is the lesser of $20 or the actual charge. For services furnished on or after January 1 of each subsequent year, the Medicare Economic Index (MEI) will update the facility fee for the originating site annually. For telehealth services furnished from October 1, 2001, through December 31, 2002, the payment amount to the originating site is the lesser of 80 percent of the actual charge or the originating site facility fee of $20. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance. The originating site facility fee payment methodology for each type of facility is clarified below:

When the originating site is a hospital outpatient department, payment for the originating site facility fee must be made as described above and not under the outpatient prospective payment system. Payment is not based on current fee schedules or other payment methodologies. For hospital inpatients, payment for the originating site facility fee must be made outside the diagnostic related group (DRG) payment since this is a Part B benefit, similar to other services paid separately from the DRG payment. When the originating site is a critical access hospital, contractors make payment separately from the cost-based reimbursement methodology.

The originating site facility fee for telehealth services is not a Federally qualified health center (FQHC) and rural health clinic (RHC) service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate. When the originating site is a physician's or practitioner's office, the payment amount, in accordance with the law, is the lesser of 80 percent of the actual charge or originating site facility fee regardless of geographic location. The geographic cost index (GPCI) should not be applied to the originating site facility fee. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the physician fee schedule.

270.5.1 - Originating Site Facility Fee Payment (ESRD-Related Services) (Rev. 31, Issued: 04-01-05; Effective: 01-01-05; Implementation: 05-02-05)

With regard to ESRD-related services included in the MCP, the originating site facility fee payment may be made for each visit furnished through an interactive telecommunications system. When the physician or practitioner at the distant site furnishes an ESRD-related patient visit(s) included in the MCP through an interactive telecommunications system, the originating site facility may bill for a telehealth facility fee.

EXAMPLE: A 70 year old ESRD beneficiary receives 2 ESRD-related visits through an interactive telecommunications system and the required face-to-face visit (to examine the vascular access site) during the month of November. In this scenario the originating site should bill for two originating site facility fees as described by HCPCS code Q3014 and the MCP physician at the distant site should bill for ESRD-related services with 2 to 3 visits as a telehealth service, e.g., G3018 "GT".

For more information on telehealth claims processing *see* Pub. 100-04, chapter 12, section 190 (Medicare telehealth claims processing).