

# Telemedicine



## **MONTANA MEDICAID PROGRAM OVERVIEW**

# What is Telemedicine



- Telemedicine is the use of interactive audio-video equipment to link practitioners and patients located at different sites.
- Telemedicine involves two collaborating providers, an originating provider and a distance provider.
  - The provider where the member is located is the originating provider or originating site.
  - The distant provider is a clinician who acts as a consultant to the member for the originating provider.

- Telemedicine should not be selected when face-to-face services are medically necessary.
- Telemedicine can be provided in a member's residence. The distance provider is responsible for the confidentiality requirements. Member's residences do not qualify for originating provider reimbursement.
  - In this case the distant provider is the only provider involved in the service.

# Confidentiality Requirements



- HEALTH BENEFITS PROVIDED THROUGH  
TELEMEDICINE MUST MEET THE SAME  
STANDARD OF CARE AS IN-PERSON CARE.**
- RECORD KEEPING SHOULD COMPLY WITH  
MEDICAID REQUIREMENTS IN  
ADMINISTRATIVE RULES OF MONTANA  
(ARM) 37.85.414**
- TRANSMISSIONS MUST BE PERFORMED ON  
DEDICATED SECURE LINES OR MUST UTILIZE  
AN ACCEPTABLE METHOD OF ENCRYPTION  
ADEQUATE TO PROTECT THE  
CONFIDENTIALITY AND INTEGRITY OF THE  
TRANSMISSION.**

# Billing Instructions



- Originating providers bill using revenue code 780 and procedure code Q3014 (telemedicine originating site fee) for use of a room and telecommunication equipment.
  - \*Reimbursement for Q3014 is a set fee and is paid outside of both the cost to charge ratio and the all-inclusive rate.
- Originating provider claims must include a specific diagnosis code to indicate why a member is being seen by the distance provider. The originating site must request the diagnosis code(s) from the distance site.
- The originating site may not bill for assisting the distant provider with an examination.

# Distance Providers



- SHOULD SUBMIT CLAIMS FOR TELEMEDICINE SERVICES USING THE APPROPRIATE CPT OR HCPCS CODE FOR THE PROFESSIONAL SERVICE ALONG WITH THE GT MODIFIER.**
- PROVIDER MUST ALSO USE THE TELEMEDICINE PLACE OF SERVICE OF 02 FOR CLAIMS SUBMITTED ON A CMS-1500 CLAIM.**
- ANY OUT OF STATE DISTANCE PROVIDER MUST BE LICENSED IN THE STATE OF MONTANA AND ENROLLED IN MONTANA MEDICAID.**
- PROVIDERS MUST CONTACT THE MONTANA DEPARTMENT OF LABOR AND INDUSTRY TO FIND OUT DETAILS ON LICENSING REQUIREMENTS FOR THEIR APPLICABLE PROFESSIONAL LICENSURE.**

# General Instructions



- **Telemedicine reimbursement does not include:**
  - Consultations provided by telephone (interactive audio); or
  - Facsimile machine transmissions
  - Crisis hotlines

The originating and distant providers may not be within the same facility or community. The same provider may not be the pay to for both the originating and distance provider.

More information can be found at: [medicaidprovider.mt.gov](http://medicaidprovider.mt.gov) under the general information for providers manual.

# Scenarios



## **FIRST SCENARIO:**

**A PROVIDER AT CROW/NORTHERN CHEYENNE HOSPITAL OFFERS SERVICES THAT A PROVIDER AT BROWNING HOSPITAL DOES NOT. THE PROVIDER AT CROW/NORTHERN CHEYENNE WOULD BE THE DISTANCE PROVIDER AND COULD BILL THE 500 REVENUE CODE FOR THE VISIT. BROWNING WOULD BE THE ORIGINATING SITE AND COULD BILL THE 780 REVENUE CODE WITH THE Q3014.**

**SITUATION: A PROVIDER IS ASSIGNED TO FT. BELKNAP SERVICE UNIT AND COVERS FOR A PERIOD OF TIME AT ANOTHER SERVICE UNIT. WHILE AT THE OTHER SERVICE UNIT, THE PROVIDER SEES HIS PATIENTS AT FT. BELKNAP VIA TELEMEDICINE. THIS DOES NOT MEET THE REQUIREMENTS FOR ORIGINATING AND DISTANCE PROVIDERS. FT. BELKNAP WOULD BILL THE 500 FOR THE VISIT WITH A GT MODIFIER.**



# Scenarios



**IF THE DISTANCE PROVIDER IS FROM AN OUT OF STATE IHS, THEY DO NOT NEED TO CONTACT THE DEPARTMENT OF LABOR OR BE LICENSED IN THE STATE OF MONTANA. THEY WILL NEED TO ENROLL IN ORDER TO GET PAID.**

**IF THEY ARE NOT WITH AN IHS, THEY WILL NEED TO BE LICENSED IN THE STATE OF MONTANA.**

# Questions?





# Dual Eligible Members



- **What to do when a member has both Medicare and Medicaid coverage.**



## Dual Eligible Beneficiaries

“Dual eligible beneficiaries” is the general term that describes individuals who are enrolled in both Medicare and Medicaid. The term includes individuals who are enrolled in Medicare Part A and/or Part B and receive full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through one of the following “Medicare Savings Program” (MSP) categories:

- **Qualified Medicare Beneficiary (QMB) Program** – Helps pay for Part A and/or Part B premiums, deductibles, coinsurance, and copayments;
- **Specified Low-Income Medicare Beneficiary (SLMB) Program** – Helps pay for Part B premiums;
- **Qualifying Individual (QI) Program** – Helps pay for Part B premiums; and
- **Qualified Disabled Working Individual (QDWI) Program** – Pays the Part A premium for certain people who have disabilities and are working.

# Medicare is always billed first



## Medicare Part A Claims

- Providers must submit these claims first to Medicare. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider. The provider then reviews the EOMB and submits the claim to Medicaid.

## Medicare Part B Claims

- Part B claims can automatically crossover to Medicaid. Providers must tell Medicare that they want their claims sent to Medicaid automatically, and must have their Medicare provider number on file with Medicaid.

# Providers should submit Medicare crossover claims to Medicaid only when:



- **The referral to Medicaid statement is missing.** In this case, submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- **The referral to Medicaid statement is present, but there is no response from Medicaid within 45 days of receiving the Medicare EOMB.**

Submit a claim and a copy of the Medicare EOMB to Medicaid for processing.

- **Medicare denies the claim.** The provider may submit the claim to Medicaid with the EOMB and denial explanation (as long as the claim has not automatically crossed over from Medicare).

- ❖ **Medicaid pays co-insurance and deductible on claims for dual eligible members.**



**MORE INFORMATION REGARDING BILLING  
MEDICARE AND MEDICAID CAN BE FOUND IN  
THE GENERAL MANUAL AT  
[MEDICAIDPROVIDER.MT.GOV](http://MEDICAIDPROVIDER.MT.GOV)**

**MORE INFORMATION REGARDING MEDICARE  
BILLING CAN BE FOUND AT  
[MED.NORIDIANMEDICARE.COM](http://MED.NORIDIANMEDICARE.COM)**



