

Transforming Episode Accountability Model (TEAM): Telehealth Waiver Billing Fact Sheet



Understanding the Telehealth Waiver

To enhance care coordination across the post-acute spectrum and support Transforming Episode Accountability Model (TEAM) participant hospitals in managing beneficiary care, the Centers for Medicare & Medicaid Services (CMS) is conditionally waiving certain Medicare Fee-for-Service (FFS) payment rules for TEAM episodes, including a waiver for telehealth use.

The Telehealth Waiver waives geographic and originating site requirements, allowing Original Medicare beneficiaries to receive evaluation and monitoring services from their home or place of residence, regardless of the location, per regulations at [42 CFR 512.580\(a\)](#).

CMS will pay claims for telehealth services delivered to patients at home or at their place of residence, regardless of location, subject to the following conditions:

- The discharge must be from a TEAM participant hospital.
- The beneficiary must have been discharged from an acute inpatient hospitalization or completed an outpatient procedure initiated by a TEAM qualifying Medicare Severity Diagnosis-Related Groups (MS-DRG) or Healthcare Common Procedure Coding System (HCPCS) code.¹
- The beneficiary must receive telehealth services within 30 days of the outpatient procedure or inpatient hospitalization.
- Telehealth services cannot replace in-person home health visits for patients under a home health episode of care. CMS will not pay for telehealth services performed by social workers for patients under a home health episode of care.
- The telehealth waiver and the allowance of the home as an originating site do not apply when a physician or an approved non-physician practitioner conducts a face-to-face visit to certify a patient's eligibility for the Medicare home health benefit.
- If the patient is at home, the telehealth service cannot be billed with a descriptor that prevents delivery of the service in a home (for example, a hospital visit code).
- When a beneficiary receives telehealth services in their home or place of residence, CMS waives the originating site requirement, and no originating site facility fee (HCPCS code Q3014) may be billed by the hospital or any other facility.
- The TEAM participant hospital must apply patient coinsurance and deductible to all telehealth services.

If you are viewing a printed version of this fact sheet, you can visit the model's webpage at <https://www.cms.gov/priorities/innovation/innovation-models/team-model> and <https://www.cms.gov/files/document/mm14215-implementing-transforming-episode-accountability-model-telehealth-waiver.pdf> to access the resources referenced here.

¹ TEAM episodes are for one of the following surgical procedures: lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedure. For a list of the HCPCS codes and MS-DRGs included in each episode category, please see [42 CFR 512.525\(d\)](#).

- The beneficiary must meet the following eligibility criteria for TEAM upon admission for an outpatient procedure or inpatient hospitalization. The following beneficiary inclusion criteria are outlined at [42 CFR 512.535\(a\)](#):
 - Enrolled in Medicare Parts A and B
 - Not eligible for Medicare on the basis of having end-stage renal disease
 - Not enrolled in any managed care plan (for example, Medicare Advantage, health care prepayment plans, or cost-based health maintenance organizations)
 - Not covered under a United Mine Workers of America health care plan
 - Have Medicare as their primary payer

How to Bill for Services Using the Telehealth Waiver

Category	Requirement
CMS Payment Policy	Waives geographic and originating site requirements to allow beneficiaries to receive telehealth services in their home during a 30-day TEAM episode. For more information, see CMS Medicare Learning Network (MLN) Matters® Article MM14215: Implementing the TEAM Telehealth Waiver . All other Medicare FFS rules for coverage and payment of Part A-covered telehealth services still apply.
Type of Claim	Type of Bill (TOB) is 13X for hospital outpatient department.
Who Must Bill	The eligible TEAM participant that provides the service.
Demonstration Code	A9: First Treatment Authorization Code Field (2300 REF02 Segment, where REF01 = P4 for electronic claims).
Required Coding	HCPCS code G0665 – G0668 as the only service on revenue code 0780. G0665: TEAM remote evaluation/management established patient 10 minutes G0666: TEAM remote evaluation/management established patient 15 minutes G0667: TEAM remote evaluation/management established patient 25 minutes G0668: TEAM remote evaluation/management established patient 40 minutes
Episode Type	TEAM outpatient or inpatient episodes.



Important Note: The regional Medicare Administrative Contractor (MAC) will return telehealth claims to the TEAM participant hospital if they do not meet these criteria or if the telehealth claim is submitted with other Medicare FFS services in the same claim.