CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 790 **Date: DECEMBER 23, 2005**

CHANGE REQUEST 4204

SUBJECT: List of Medicare Telehealth Services

I. SUMMARY OF CHANGES: In the calendar year 2006 physician fee schedule-final rule, the list of Medicare telehealth services was expanded to include individual medical nutrition therapy as described by HCPCS codes G0270, 97802 and 97803. A registered dietitian and nutrition professional were added to the list of practitioners that may furnish and receive payment for a telehealth service. Chapter 12, sections 190.3, 190.5, 190.6.1 and 190.7 have been revised to implement this addition to the list of Medicare telehealth services. Additionally, section 190.6 was updated to include the revenue code rural health clinics and Federally qualified health centers currently use when billing for the telehealth originating site facility fee. The revision to section 190.6 is not a change, rather it parallels material already contained in Pub.100-04, chapter 9.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 1, 2006
IMPLEMENTATION DATE: April 3, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	12/Table of Contents
R	12/190.3/List of Medicare Telehealth Services
R	12/190.5/Payment Methodology for Physician/Practitioner at the Distant Site
R	12/190.6/Originating Site Facility Fee Payment Methodology
R	12/190.6.1/Submission of Telehealth Claims for Distant Site Practitioners
R	12/190.7/Contractor Editing of Telehealth Claims

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 790	Date: December 23, 2005	Change Request 4204

SUBJECT: List of Medicare Telehealth Services

I. GENERAL INFORMATION

A. Background: As part of CMS' process for adding services to the list of Medicare telehealth services, CMS added individual medical nutrition therapy (MNT) as represented by HCPCS codes G0270, 97802 and 97803 to the list of Medicare telehealth services. Additionally, since a certified registered dietitian and nutrition professional as defined in 42 CFR, §410.134 are the only practitioners permitted by law to furnish MNT, a registered dietitian and nutrition professional have been added to the list of practitioners that may furnish and receive payment for a telehealth service. This addition to the list of telehealth services and list of practitioners eligible to furnish a telehealth service was announced in the calendar year 2006 physician fee schedule, final rule (CMS-1502-FC).

B. Policy: The list of Medicare telehealth services has been expanded to include individual MNT as described by HCPCS codes G0270, 97802 and 97803. Effective January 1, 2006, the telehealth modifiers "GT" (via interactive audio and video telecommunications system) and modifier "GQ" (via asynchronous telecommunications system) are valid when billed with these HCPCS codes. This expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, payment or billing methodology applicable to Medicare telehealth services as set forth in Pub. 100-02, chapter 15, section 270 and Pub. 100-04, chapter 12, section 190. For example, originating sites only include a physician's or practitioner's office, hospital, critical access hospital (CAH), rural health clinic, or Federally qualified health center. Originating sites must be located in either a non-MSA county or rural health professional shortage area. An interactive audio and video telecommunications system 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. The only exception to the interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In this circumstance, Medicare payment is permitted for telehealth services when asynchronous store and forward technology is used. For more information on Medicare telehealth payment policy and claims processing instructions see Pub. 100-02, chapter 15, section 270 and Pub. 100-04, chapter 12, section 190.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4204.1	Effective January 1, 2006, local part B Carriers shall pay for HCPCS codes G0270, 97802, and 97803 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier.			X						
4204.2	Effective January 1, 2006, local FIs shall pay for HCPCS codes G0270, 97802, and 97803 when submitted with a GT or GQ modifier, by hospital or CAH outpatient departments. FISS shall make the necessary changes to allow for this payment.	X				X				
4204.3	Contractors do not have to search their files and reprocess claims for HCPCS codes G0270, 97802, and 97803 with dates of service on or after January 1, 2006. However, contractors shall adjust any claims for these services that are brought to their attention.	X		X		X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4204.4	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the	X		X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** Policy: Craig Dobyski (410) 786-4584; Craig.Dobyski@cms.hhs.gov Carrier Claims Processing: Kathy Kersell (410) 786-2033; Kathleen.Kersell@cms.hhs.gov FI Claims Processing for CAH Method II claims: Doris Barham, (410) 786-6146; Doris.Barham@cms.hhs.gov. All other institutional billing questions on telehealth services should be directed to: Gertrude Saunders, (410) 786-5888; Gertrude.Saunders@cms.hhs.gov. **Post-Implementation Contact(s): A**ppropriate Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

*__Unless otherwise specified, the effective date is the date of service.__

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents

(Rev. 790, 12-23-05)

190.3 - List of Medicare Telehealth Services

(Rev. 790, Issued: 12-23-05; Effective: 01-01-06; Implementation: 04-03-06)

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. These services and corresponding current procedure terminology (CPT) codes are listed below.

- Consultations (CPT codes 99241 - 99275);
- Office or other outpatient visits (CPT codes 99201 - 99215);
- Individual psychotherapy (CPT codes 90804 - 90809);
- Pharmacologic management (CPT code 90862); and
- Psychiatric diagnostic interview examination (CPT code 90801) – Effective March 1, 2003.
- End Stage Renal Disease (ESRD) 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).*

190.5 - Payment Methodology for Physician/Practitioner at the Distant Site

(Rev. 790, Issued: 12-23-05; Effective: 01-01-06; Implementation: 04-03-06)

1. Distant Site Defined

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.

2. Payment Amount (professional fee)

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 an office visit, consultation, individual psychotherapy or pharmacologic management via a telecommunications system 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.

3. Medicare Practitioners Who May Receive Payment at the Distant Site (i.e., at a site other than where 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 (i.e., professional consultation, office and other

outpatient visits, individual psychotherapy, and pharmacologic management) then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

If the physician or practitioner at the distant site is located in a critical access hospital (CAH) that has elected Method II, and the physician or practitioner has reassigned his/her benefits to the CAH, the CAH bills its regular FI for the professional services provided at the distant site via a telecommunications system, in any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply.

4. Medicare Practitioners Who May Bill for Covered Telehealth Services are Listed Below (subject to State law)

Physician.

Nurse practitioner.

Physician assistant.

Nurse-midwife.

Clinical nurse specialist.

Clinical psychologist.*

Clinical social worker.*

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.

190.6 - Originating Site Facility Fee Payment Methodology

(Rev. 790, Issued: 12-23-05; Effective: 01-01-06; Implementation: 04-03-06)

1. Originating site defined

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.

2. Facility fee for originating site (See B, above, for definition of originating site.)

The originating site facility fee is a Part B payment. The contractor pays it outside of the current fee schedule or other payment methodologies (e.g., FIs make payment in addition to the DRG, or OPPS). For consultation, office or other outpatient visit, psychotherapy and pharmacologic management services delivered via a telecommunications system 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 site fee for the originating site annually. This fee is subject to post payment verification.

3. Payment amount:

For telehealth services furnished from October 1, 2001, through December 31, 2002, the payment amount to the originating site is the lesser 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.

Hospital outpatient department. 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.

Hospital inpatient. 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, (e.g., hemophilia blood clotting factor).

Critical access hospitals. When the originating site is a critical access hospital, make payment as described above, separately from the cost-based reimbursement methodology.

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

Physicians' and practitioners' offices. When the originating site is a physician's or practitioner's office, the payment amount, in accordance with the law, is the lesser of the actual charge or $20 regardless of geographic location. The carrier shall not apply the geographic practice cost index (GPCI) to the originating site facility fee. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the physician fee schedule.

To receive the originating facility site fee, the provider submits claims with HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." The type of service for the telehealth originating site facility fee is "9, other items and services." For carrier-processed claims, the "office" place of service (code 11) is the only payable setting for code Q3014. There is no participation payment differential for code Q3014 and it is not priced off of the MPFS Database file. Deductible and coinsurance rules apply to Q3014. By submitting Q3014 HCPCS code, the originating site authenticates they are located in either a rural HPSA or non-MSA county.

This benefit may be billed on bill types 13X, 71X, 73X, and 85X. The originating site can be located in a number of revenue centers within a facility, such as an emergency room (0450), operating room (0360), or clinic (0510). Report this service under the revenue center where the service was performed and include HCPCS code "Q3014, telehealth originating site facility fee."

Hospitals and critical access hospitals bill their intermediary for the originating site facility fee. Telehealth bills originating in inpatient hospitals must be submitted on an 13X (outpatient) TOB using the date of discharge as the line item date of service.

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

The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.

190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners

(Rev. 790, Issued: 12-23-05; Effective: 01-01-06; Implementation: 04-03-06)

Claims for professional consultations, office visits, individual psychotherapy, and pharmacologic management provided via a telecommunications system are submitted to the *contractors* that process claims for the performing physician/practitioner's service area. Physicians/practitioners submit the appropriate CPT procedure code for covered professional telehealth services along with the "GT" modifier ("via interactive audio and video telecommunications system"). By coding and billing the "GT" modifier with a covered telehealth procedure code, the distant site physician/practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished. Also, by coding and billing the "GT" modifier with a covered ESRD-related service telehealth code (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318), the distant site physician/practitioner certifies that 1 visit per month was furnished face-to-face "hands on" to examine the vascular access site. Refer to Pub. 100-02, Chapter 15, Section 270.4.1 for the coverage policy.

In situations where a CAH has elected payment Method II for CAH outpatients, and the practitioner has reassigned his/her benefits to the CAH, FIs should make payment for telehealth services provided by the physician or practitioner according to instruction in Pub. 100-04, Chapter 4, Section 250.2. In all other cases, except for MNT services as discussed in 190.7-Contractor Editing of Telehealth Claims, telehealth services provided by the physician or practitioner at the distant site are billed to the carrier.

Physicians and practitioners at the distant site bill their local Medicare carrier for covered telehealth services, for example, "99245 GT." Physicians' and practitioners' offices serving as a telehealth originating site bill their local Medicare carrier for the originating site facility fee.

190.7 –*Contractor* Editing of Telehealth Claims

(Rev. 790, Issued: 12-23-05; Effective: 01-01-06; Implementation: 04-03-06)

Effective October 1, 2001, covered telehealth services include CPT codes 99241 – 99275, 99201 – 99215, 90801 (effective March 1, 2003), 90804 - 90809, and 90862. Effective January 1, 2005, covered telehealth services also include HCPCS codes G0308, G0309,

G0311, G0312, G0314, G0315, G0317, and G0318. *Effective January 1, 2006, covered telehealth services also include HCPCS codes G0270, 97802, 97803.* When furnished as telehealth services these codes are billed with either the "GT" or "GQ" modifier.

The *contractor* shall approve covered telehealth services if the physician or practitioner is licensed under State law to provide the service. *Contractors* must familiarize themselves with licensure provisions of States for which they process claims and disallow telehealth services furnished by physicians or practitioners who are not authorized to furnish the applicable telehealth service under State law. For example, if a nurse practitioner is not licensed to provide individual psychotherapy under State law, he or she would not be permitted to receive payment for individual psychotherapy under Medicare. The *contractor* shall install edits to ensure that only properly licensed physicians and practitioners are paid for covered telehealth services.

If a *contractor* receives claims for professional telehealth services coded with the "GQ" modifier (representing "via asynchronous telecommunications system"), it shall approve/pay for these services only if the physician or practitioner is affiliated with a Federal telemedicine demonstration conducted in Alaska or Hawaii. The *contractor* may require the physician or practitioner at the distant site to document his or her participation in a Federal telemedicine demonstration program conducted in Alaska or Hawaii prior to paying for telehealth services provided via asynchronous, store and forward technologies.

If a *contractor* denies telehealth services because the physician or practitioner may not bill for them, the *contractor* uses MSN message 21.18: "This item or service is not covered when performed or ordered by this practitioner." The *contractor* uses remittance advice message 52 when denying the claim based upon MSN message 21.18.

If a service is billed with one of the telehealth modifiers and the procedure code is not designated as a covered telehealth service, the *contractor* denies the service using MSN message 9.4: "This item or service was denied because information required to make payment was incorrect." The remittance advice message depends on what is incorrect, e.g., B18 if procedure code or modifier is incorrect, 125 for submission billing errors, 4-12 for difference inconsistencies. The *contractor* uses B18 as the explanation for the denial of the claim.

The only claims from institutional facilities that FIs shall pay for telehealth services at the distant site, except for MNT services, are for physician or practitioner services when the distant site is located in a CAH that has elected Method II, and the physician or practitioner has reassigned his/her benefits to the CAH. The CAH bills its regular FI for the professional services provided at the distant site via a telecommunications system, in any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply.

Claims from hospitals or CAHs for MNT services are submitted to the hospital's or CAH's regular FI. Payment is based on the non-facility amount on the Medicare Physician Fee Schedule for the particular HCPCS codes.