CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 105	**Date: APRIL 24, 2009**
	Change Request 6458

SUBJECT: List of Medicare Telehealth Services

I. SUMMARY OF CHANGES: The 2009 Healthcare Procedural Coding System (HCPCS) update added several new CPT procedure codes related to End Stage Renal Disease (ESRD) services and deleted the related G-codes, effective for dates of service on or after January 1, 2009. A number of these ESRD-related services are on the list of approved telehealth services. The list of approved telehealth services must be updated to reflect the deletion of the G-codes and the addition of the CPT codes. Therefore, CMS is updating the list of Medicare Telehealth Services to reflect the coding changes for ESRD-related services that took effect during the 2009 HCPCS update. The established policy for telehealth services has not changed.

New / Revised Material
Effective Date: January 1, 2009
Implementation Date: May 26, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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 is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	15/270/270.5.1/Originating Site Facility Fee Payment (ESRD-Related Services)

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-02	Transmittal: 105	Date: April 24, 2009	Change Request: 6458

SUBJECT: List of Medicare Telehealth Services

Effective Date: January 1, 2009
Implementation Date: May 26, 2009

I. GENERAL INFORMATION

A. Background: The 2009 Healthcare Procedural Coding System (HCPCS) update added several new CPT procedure codes related to End Stage Renal Disease (ESRD) services and deleted the related G-codes, effective for dates of service on or after January 1, 2009. A number of these ESRD-related services are on the list of approved telehealth services. These new CPT codes replaced several "G" codes used for ESRD related telehealth services.

B. Policy: CMS is updating the list of Medicare Telehealth Services to reflect the coding changes for ESRD-related services that took effect during the 2009 HCPCS update. The established policy for telehealth services has not changed.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6458.1	Effective January 1, 2009, contractors (local Part B carriers and/or A/B MACs) shall pay for CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier.	X			X						
6458.2	Effective January 1, 2009, contractors (local FIs and/or A/B MACs) shall pay for CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier by CAHs that have elected Method II on TOB 85X.	X		X							
6458.3	Contractors do not have to search their files and reprocess claims for CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961 with dates of service on or after January 1, 2009, but shall adjust any claims for these services that are brought to their attention. **NOTE:** These CPT codes replace codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 that were deleted during the 2009 HCPCS Update.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6458.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN 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. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s):
Policy: Esther Markowitz: esther.markowitz@cms.hhs.gov , 410-786-4565.
Part A claims processing: Gertrude Saunders: gertrude.saunders@cms.hhs.gov , 410-786-5888.
Part B claims processing: Kathleen Kersell: kathleen.kersell@cms.hhs.gov , 410-786-2033.

Post-Implementation Contact(s): Appropriate Regional Office or MAC Project Officer.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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

Section B: ***For Medicare Administrative Contractors (MACs),*** **include the following statement:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

270.5.1 - Originating Site Facility Fee Payment (ESRD-Related Services)

(Rev. 105, Issued: 04-24-09; Effective: 01-01-09; Implementation: 05-26-09)

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 *with the* "GT" *modifier.*

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