CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 118	**Date: DECEMBER 18, 2009**
	Change Request 6705

SUBJECT: Expansion of Medicare Telehealth Services for CY 2010

I. SUMMARY OF CHANGES: In the calendar year 2010 physician fee schedule final rule with comment period (CMS-1413-FC), CMS added three codes to the list of Medicare distant site telehealth services for individual health and behavior assessment and intervention (HBAI) services and three codes for initial inpatient telehealth consultations. CMS also expanded the definition of follow-up inpatient telehealth consultations to include consultative visits furnished via telehealth to beneficiaries in hospitals or SNFs. These codes are included in the CY 2010 HCPCS annual update. This CR adds the relevant policy instructions to the manuals, as finalized in the regulations.

To eliminate redundancy, this CR also deletes Section 270.2.1, "Follow-Up Inpatient Telehealth Consultations Defined." Claims processing instructions and the definition of follow-up inpatient telehealth consultations can be found in Pub 100-04, Chapter 12, Section 190.3.3.

New / Revised Material
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

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	15/270/270.2/List of Medicare Telehealth Services
D	15/270/270.2.1/Follow-Up Inpatient Telehealth Consultations Defined

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: 118	Date: December 18, 2009	Change Request: 6705

SUBJECT: Expansion of Medicare Telehealth Services for CY 2010

Effective Date: January 1, 2010
Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A. Background: In the calendar year 2010 physician fee schedule final rule with comment period (CMS-1413-FC), CMS added three codes to the list of Medicare distant site telehealth services for individual health and behavior assessment and intervention (HBAI) services and three codes for initial inpatient telehealth consultations. CMS also expanded the definition of follow-up inpatient telehealth consultations to include consultative visits furnished via telehealth to beneficiaries in SNFs. These codes are included in the CY 2010 HCPCS annual update. This CR adds the relevant policy instructions to the manuals, as finalized in the regulations.

B. Policy: The list of Medicare telehealth services was expanded to include individual HBAI, as described by HCPCS codes 96150-96152, and initial inpatient telehealth consultations, as described by HCPCS codes G0425-G0427. Effective January 1, 2010, the telehealth modifier "GT" (via interactive audio and video telecommunications system) and modifier "GQ" (via asynchronous telecommunications system) are valid when billed with these HCPCS codes. In addition, effective January 1, 2010, follow-up inpatient telehealth consultations, as described by HCPCS codes G0406-G0408, are valid when billed for services furnished to beneficiaries in hospitals or SNFs.

Effective January 1, 2010, CMS eliminated the use of all consultation CPT codes. CMS will issue a separate change request to address the revisions in consultation services payment policy. Because revisions in consultation services payment policy affect telehealth policy, this change request includes references to the revisions relevant to professional consultations furnished via telehealth.

As a result of this change to the use of consultation CPT codes, CMS will no longer recognize office/outpatient consultation CPT codes 99241-99245. Instead, physicians and practitioners are instructed to bill a new or established patient visit CPT code (in the range of CPT codes 99201-99215), as appropriate to the particular patient, for all office/outpatient visits furnished via telehealth. CMS will no longer recognize initial inpatient consultation CPT codes 99251-99255. Instead, CMS created HCPCS codes G0425-G0427 specific to the telehealth delivery of initial inpatient consultations to retain the ability for practitioners to furnish and bill for initial inpatient consultations delivered via telehealth.

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. Consistent with existing telehealth policy, all telehealth services must be billed with either the "GT" or "GQ" modifier to identify the telehealth technology used to provide the service. For more information on Medicare telehealth payment policy and claims processing instructions, see Pub. 100-02, chapter 15, sections 270 through 270.5.1 and Pub. 100-04, chapter 12, sections 190 through 190.7.

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	
6705.1	Effective January 1, 2010, Medicare contractors shall pay for HCPCS codes 96150-96152 and G0425-G0427 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier. **NOTE:** The type of service for G0425-G0427 is 3 (consultation). Also, codes G0425-G0427 are included in the CY 2010 HCPCS annual update.	X			X						
6705.2	Effective January 1, 2010, Medicare contractors shall pay follow-up inpatient telehealth consultation codes G0406-G0408 with the GT or GQ modifier when billed with place of service (POS) inpatient hospital or skilled nursing facility (SNF). **NOTE:** These codes were effective January 1, 2009, and were only valid for POS inpatient hospital; they now have been expanded to include POS SNF.	X			X						
6705.3	Effective January 1, 2010, Medicare contractors shall pay initial inpatient telehealth consultation codes G0425-G0427 with the GT or GQ modifier when billed with POS inpatient hospital or skilled nursing facility (SNF).	X			X						
6705.4	Effective January 1, 2010, Medicare contractors shall pay for HCPCS codes 96150-96152 and G0425-G0427 when submitted with a GT or GQ modifier, by CAHs that have elected Method II on TOB 85x.	X		X							
6705.5	Medicare contractors shall remove codes 99241 through 99255 from the list of telehealth services for dates of service on or after January 1, 2010. These codes were discontinued with the 2010 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	
6705.6	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: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Policy: Gail Addis: Gail.Addis@cms.hhs.gov: 410-786-4522
Carrier claims processing: Kathy Kersell: Kathleen.Kersell@cms.hhs.gov: 410-786-2033
Intermediary claims processing: Gertrude Saunders: Gertrude.Saunders@cms.hhs.gov: 410-786-5888

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)* 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.

270.2 – List of Medicare Telehealth Services

(Rev. 118; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

Furnished by CMS

The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for *professional* consultation*s*, office visits, *office psychiatry services, and a limited number of other physician fee schedule (PFS) services.* These services are listed below.

Consultations *(Effective October 1, 2001- December 31, 2009)*

Initial inpatient telehealth consultations (Effective January 1, 2010)

Follow-up inpatient telehealth consultations (Effective January 1, 2009)

Office or other outpatient visits

Individual psychotherapy

Pharmacologic management

Psychiatric diagnostic interview examination (Effective March 1, 2003)

End stage renal disease related services (Effective January 1, 2005)

Individual Medical Nutrition Therapy (Effective January 1, 2006)

Neurobehavioral status exam (Effective January 1, 2008)

Individual health and behavior assessment and intervention (Effective January 1, 2010)

NOTE: *Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS will no longer recognize office/outpatient consultation CPT codes for payment of office/outpatient visits. Instead, physicians and practitioners are instructed to bill a new or established patient visit CPT code, as appropriate to the particular patient, for all office/outpatient visits.* For detailed coding for these *and other telehealth* services, see Pub.100-04, chapter 12, §190.3.

The conditions of payment for Medicare telehealth services, including qualifying originating sites and the types of telecommunications systems recognized by Medicare, are subject to the provisions of 42 CFR 410.78. Payment for these services is subject to the provisions of 42 CFR 414.65.