CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 140	**Date: February 28, 2011**
	Change Request 7049

Transmittal 131, dated August 20, 2010, is being rescinded and replaced by Transmittal 140, dated February 28, 2011. April 4, 2011 is being added as an implementation date, and FISS is being added as a responsible party for Business Requirement 7049.2. Additionally, a new Business Requirement 7049.3 is added. The Provider Education requirement number is now 7049.4. All other information remains the same.

SUBJECT: Expansion of Medicare Telehealth Services for CY 2011

I. SUMMARY OF CHANGES: CMS has added codes to the list of Medicare Telehealth Services.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011 for A/B MACs and Carriers; April 4, 2011 for A/B MACs and Fiscal Intermediaries

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/Table of Contents
R	15/270/Telehealth Services
R	15/270.2/List of Medicare Telehealth Services
R	15/270.4/Payment - Physician/Practitioner at a Distant Site
N	15/270.4.2/Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services

N	15/270.4.3/Payment for Diabetes Self Management Training (DSMT) as a Telehealth Service

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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: 140	Date: February 28, 2011	Change Request: 7049

Transmittal 131, dated August 20, 2010, is being rescinded and replaced by Transmittal 140, dated February 28, 2011. April 4, 2011 is being added as an implementation date, and FISS is being added as a responsible party for Business Requirement 7049.2. Additionally, a new Business Requirement 7049.3 is added. The Provider Education requirement number is now 7049.4. All other information remains the same.

SUBJECT: Expansion of Medicare Telehealth Services for CY 2011

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011 for A/B MACs and Carriers; April 4, 2011 for A/B MACs and Fiscal Intermediaries

I. GENERAL INFORMATION

Background: CMS has added 14 codes to the list of Medicare distant site telehealth services for individual and group Kidney Disease Education (KDE) services, individual and group Diabetes Self Management Training (DSMT) services, group Medical Nutrition Therapy (MNT) services, group Health and Behavior Assessment and Intervention (HBAI) services, and subsequent hospital care and nursing facility care services to the list of telehealth services for which payment will be made at the applicable PFS payment amount for the service of the physician or practitioner.

B. Policy: CMS is adding the following requested services to the list of Medicare telehealth Services for CY 2011:

- Individual and group KDE services (HCPCS codes G0420 and G0421, respectively);
- Individual and group DSMT services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training (HCPCS codes G0108 and G0109, respectively);
- Group MNT and HBAI services (CPT codes 97804, and 96153 and 96154, respectively);
- Subsequent hospital care services, with the limitation of one telehealth visit every 3 days (CPT codes 99231, 99232, and 99233); and
- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days (CPT codes 99307, 99308, 99309, and 99310).

CMS also limited the use of telehealth in two ways. First, for hospital care services, CMS limited the patient's admitting physician or practitioner to one telehealth visit every 3 days. For subsequent nursing facility care services, CMS limited the patient's admitting physician or non-physician practitioner to one telehealth visit every 30 days. Also, for DSMT, CMS required a minimum of 1 hour of in-person instruction to be furnished in the year following the initial training to ensure effective injection training.

II. BUSINESS REQUIREMENTS 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	
7049.1	For dates of service on or after January 1, 2011, contractors (local Part B carriers and/or A/B MACs) shall accept and pay the following codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ or GT modifier: G0108 – G0109; G0420 – G0421; 96153 – 96154; 97804; 99231 – 99233; 99307 – 99310.	X			X						
7049.2	For dates of service on or after January 1, 2011, contractors (local FIs and/or A/B MACs) shall accept and pay the following codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ or GT modifier by CAHs that have elected Method II on TOB 85X: G0108 – G0109; G0420 – G0421; 96153 – 96154; 97804; 99231 – 99233; 99307 – 99310.	X		X			X				
7049.3	A/B MACs and Fiscal Intermediaries need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention.	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	
7049.4	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: N/A

V. CONTACTS

Pre-Implementation Contact(s): Policy: Ryan Howe at ryan.howe@cms.hhs.gov, or 410-786-3355.
Part A claims processing: Tracey Mackey at tracey.mackey@cms.hhs.gov, or 410-786-5736.
Part B claims processing: Kathleen Kersell at kathleen.kersell@cms.hhs.gov, or 410-786-2033.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *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.

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

Table of Contents

(Rev.140, 02-28-11)

270 - Telehealth Services

(Rev.140, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs, Carriers/04-04-11 A/B MACs, FIs)

Background

Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) - Revision of Medicare Reimbursement for Telehealth Services amended §1834 of the Act to provide for an expansion of Medicare payment for telehealth services.

Effective October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system. E ligible geographic areas include rural health professional shortage areas *(HPSA)* and counties not classified as a metropolitan statistical area (MSA). Additionally, Federal telemedicine demonstration projects as of December 31, 2000, may serve as the originating site regardless of geographic location.

An interactive telecommunications system is required as a condition of payment; however, BIPA does allow the use of asynchronous "store and forward" technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. BIPA does not require that a practitioner present the patient for interactive telehealth services.

With regard to payment amount, BIPA specified that payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at time of telemedicine encounter) is equal to what would have been paid without the use of telemedicine. Distant site practitioners include only a physician as described in §1861(r) of the Act and a medical practitioner as described in §1842(b)(18)(C) of the Act. BIPA also expanded payment under Medicare to include a $20 originating site facility fee (location of beneficiary).

Previously, the Balanced Budget Act of 1997 (BBA) limited the scope of Medicare telehealth coverage to consultation services and the implementing regulation prohibited the use of an asynchronous 'store and forward' telecommunications system. The BBA of 1997 also required the professional fee to be shared between the referring and consulting practitioners, and prohibited Medicare payment for facility fees and line charges associated with the telemedicine encounter.

The BIPA required that Medicare Part B (Supplementary Medical Insurance) pay for this expansion of telehealth services beginning with services furnished on October 1, 2001.

Section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended §1834(m) of the Act to add certain entities as originating sites for payment of telehealth services. Effective for services furnished on or after January 1, 2009, eligible originating sites include a hospital-based or critical access hospital-based renal dialysis center (including satellites); a skilled nursing facility (as defined in §1819(a) of the Act); and a community mental health center (as defined in §1861(ff)(3)(B) of the Act). MIPPA also amended§1888(e)(2)(A)(ii) of the Act to exclude telehealth services furnished under §1834(m)(4)(C)(ii)(VII) from the

consolidated billing provisions of the skilled nursing facility prospective payment system (SNF PPS).

NOTE: MIPPA did not add independent renal dialysis facilities as originating sites for payment of telehealth services.

The telehealth provisions authorized by §1834(m) of the Act are implemented in 42 CFR 410.78 and 414.65.

270.2 – List of Medicare Telehealth Services

(Rev.140, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs, Carriers/04-04-11 A/B MACs, FIs)

The use of a telecommunications system may substitute for a*n in-person* encounter for professional consultations, 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

Subsequent hospital care services (with the limitation of one telehealth visit every 3 days) (Effective January 1, 2011)

Subsequent nursing facility care services (with the limitation of one telehealth visit every 30 days) (Effective January 1, 2011)

Individual psychotherapy

Pharmacologic management

Psychiatric diagnostic interview examination (Effective March 1, 2003)

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

Individual *and group* medical nutrition therapy *(Individual* effective January 1, 2006*; group effective January 1, 2011)*

Neurobehavioral status exam (Effective January 1, 2008)

Individual *and group* health and behavior assessment and intervention *(Individual effective* January 1, 2010; *group effective January 1, 2011)*

Individual and group kidney disease education (KDE) services (Effective January 1, 2011)

Individual and group diabetes self-management training (DSMT) services (with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training) (Effective January 1, 2011)

NOTE: Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer *recognizes* office/outpatient *or inpatient* consultation CPT codes for payment of office/outpatient *or inpatient* visits. Instead, physicians and practitioners are instructed to bill a new or established patient *office/outpatient* visit CPT code *or appropriate hospital or nursing facility care code,* as appropriate to the particular patient, for all office/outpatient *or inpatient* visits. For detailed *instructions regarding reporting* these and other telehealth services, see Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 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.

270.4 – Payment – Physician/Practitioner at a Distant Site

(Rev.140, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs, Carriers/04-04-11 A/B MACs, FIs)

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.

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 *physician* fee schedule amount for the service. Payment for telehealth services (see section 270.2 *of this chapter*) 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.

Medicare Practitioners Who May Receive Payment at the Distant Site (i.e., at a Site Other Than Where *the* Beneficiary is *Located)*

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 (see section 270.2 *of this chapter*) then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

Medicare practitioners who may bill for a covered telehealth service are listed below (subject to State law):

Physician;
Nurse practitioner;
Physician assistant;
Nurse midwife;
Clinical nurse specialist;
Clinical psychologist;
Clinical social worker; and
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.

270.4.2 – Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services

(Rev.140, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs, Carriers/04-04-11 A/B MACs, FIs)

Subsequent hospital care services are limited to one telehealth visit every 3 days. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes.

Similarly, subsequent nursing facility care services are limited to one telehealth visit every 30 days. Furthermore, subsequent nursing facility care services reported for a Federally-mandated periodic visit under 42 CFR 483.40(c) may not be furnished through telehealth. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes.

Inpatient telehealth consultations are furnished to beneficiaries in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. Initial and follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 190.3.

270.4.3 – Payment for Diabetes Self-Management Training (DSMT) as a Telehealth Service

(Rev.140, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs, Carriers/04-04-11 A/B MACs, FIs)

Individual and group DSMT services may be paid as a Medicare telehealth service; however, at least 1 hour of the 10 hour benefit in the year following the initial DSMT service must be furnished in-person to allow for effective injection training. The injection training may be furnished through either individual or group DSMT services. By reporting the –GT or –GQ modifier with HCPCS code GO108 (Diabetes outpatient self-management training services, individual, per 30 minutes) or G0109 Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes), the distant site practitioner certifies that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training during the year following the initial DSMT service.

*As specified in 42 CFR 410.141(e) and stated in section 300.2 of this chapter, individual DSMT services may be furnished by a physician, individual, or entity that furnishes other services for which direct Medicare payment may be made and that submits necessary documentation to, and is accredited by, an accreditation organization approved by CMS. However, consistent with the statutory requirements of section 1834(m)(1) of the Act, as provided in 42 CFR 410.78(b)(1) and (b)(2) and stated in section 270.4 of this chapter**,** Medicare telehealth services, including individual DSMT services furnished as a telehealth service, could only be furnished by a licensed physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse-midwife (CNM), clinical psychologist, clinical social worker, or registered dietitian or nutrition professional.*