CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1716	**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	12/190/190.3/List of Medicare Telehealth Services
R	12/190/190.6.1/Submission of Telehealth Claims for Distant Site Providers

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. 100-04	Transmittal: 1716	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.

190.3 - List of Medicare Telehealth Services

(Rev. 1716, Issued: 04-24-09; Effective: 01-01-09; Implementation: 05-26-09)

The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, end stage renal disease related services, and individual medical nutrition therapy. These services and corresponding current procedure terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes are listed below.

- Consultations (CPT codes 99241 - 99275) - Effective October 1, 2001 – December 31, 2005;
- Consultations (CPT codes 99241 - 99255) - Effective January 1, 2006;
- Office or other outpatient visits (CPT codes 99201 - 99215);
- Individual psychotherapy (CPT codes 90804 - 90809);
- Pharmacologic management (CPT code 90862);
- 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 – *December 31, 2008*;
- *End Stage Renal Disease (ESRD) related services (CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961) – Effective January 1, 2009;*
- Individual Medical Nutrition Therapy (HCPCS codes G0270, 97802, and 97803) - Effective January 1, 2006;
- Neurobehavioral status exam (CPT code 96116) - Effective January 1, 2008; and
- Follow-up inpatient telehealth consultations (HCPCS codes G0406, G0407, and G0408) - Effective January 1, 2009.

190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners

(Rev. 1716, Issued: 04-24-09; Effective: 01-01-09; Implementation: 05-26-09)

Claims for telehealth services are submitted to the contractors that process claims for the performing physician/practitioner's service area. Physicians/practitioners submit the appropriate HCPCS 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. By coding and billing the "GT" modifier with a covered ESRD-related service telehealth code, 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 conditions of telehealth payment for ESRD-related services.

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 at 80 percent of the MPFS amount for the distant site service. In all other cases, except for MNT services as discussed in *Section* 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.