CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 178	**Date: December 30, 2013**
	Change Request 8553

SUBJECT: Expansion of Medicare Telehealth Services for CY 2014

I. SUMMARY OF CHANGES: In the calendar year 2014 physician fee schedule final rule with comment period, CMS is finalizing a proposal to add 2 codes to the list of Medicare telehealth services. Additionally, CMS is finalizing a proposal to modify regulations describing eligible telehealth originating sites to include health professional shortage areas (HPSAs) located in rural census tracts of urban areas as determined by the Office of Rural Health Policy (ORHP), effective January 1, 2014. Finally, CMS is finalizing a proposal to establish geographic eligibility for Medicare telehealth originating sites for each calendar year based upon the status of the area as of December 31st of the prior calendar year.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

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	15/270/270.1/Eligibility Criteria
R	15/270/270.2/List of Medicare Telehealth Services

III. FUNDING:
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 obliged 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: 178	Date: December 30, 2013	Change Request: 8553

SUBJECT: Expansion of Medicare Telehealth Services for CY 2014

EFFECTIVE DATE: January 1, 2014
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I. GENERAL INFORMATION

A. Background: In the calendar year 2014 physician fee schedule final rule with comment period, CMS is finalizing a proposal to add 2 codes for Transitional Care Management to the list of Medicare telehealth services. Additionally, CMS is finalizing a proposal to modify regulations describing eligible telehealth originating sites to include health professional shortage areas (HPSAs) located in rural census tracts of urban areas as determined by the Office of Rural Health Policy (ORHP), effective January 1, 2014. Finally, CMS is finalizing a proposal to establish geographic eligibility for Medicare telehealth originating sites for each calendar year based upon the status of the area as of December 31st of the prior calendar year.

B. Policy: CMS is adding the following services to the list of Medicare telehealth services for CY 2014:

- CPT code 99495: Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. Medical decision making of at least moderate complexity during the service period. Face-to-face visit, within 14 calendar days of discharge.

- CPT Code 99496: Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. Medical decision making of high complexity during the service period. Face-to-face visit, within 7 calendar days of discharge.

This policy will allow the required face-to-face visit component of both services to be furnished through telehealth.

CMS is finalizing the regulatory definition of "rural HPSA" for purposes of determining eligibility for Medicare telehealth originating sites to include HPSAs located in rural census tracts as determined by ORHP.

CMS is also finalizing a change in policy so that geographic eligibility for an originating site would be established and maintained on an annual basis, consistent with other telehealth payment policies. Absent this proposed change, the status of a geographic area's eligibility for telehealth originating site payment is effective at the same time as the effective date for changes in designations that are made outside of CMS. Accordingly, CMS is revising regulations at §410.78(b)(4) to conform with both of these policies.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8553.1	For dates of service on or after January 1, 2014, contractors shall accept and pay the following codes when submitted with a GQ or GT modifier: 99495 - 99496.		X							
8553.2	For dates of service on or after January 1, 2014, contractors 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: 99495 - 99496.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8553.3	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's 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			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Chanelle Jones, 410-786-9668 or chanelle.jones@cms.hhs.gov, Ryan Howe, 410-786-3355 or ryan.howe@cms.hhs.gov, Tracey Mackey, 410-786-5736 or tracey.mackey@cms.hhs.gov, Simone Dennis, 410-786-8409 or simon.dennis@cms.hhs.gov

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

VI. FUNDING

Section A: 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.

270.1 - Eligibility Criteria

(Rev.178, Issued: 12-30-13; Effective: 1-1-14, Implementation: 1-6-14)

Beneficiaries are eligible for telehealth services **only** if they are presented from an originating site located either in a rural HPSA or in a county outside of an MSA.

Effective January 1, 2014, rural HPSAs include HPSAs located outside of a county outside of an MSA as well as those located in rural census tracts as determined by the Office of Rural Health Policy. Also effective January 1, 2014, geographic eligibility for an originating site is established for each calendar year based upon the status of the area as of December 31st of the prior calendar year.

Entities participating in a Federal telemedicine demonstration project that were approved by or were receiving funding from the Secretary of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location. Such entities are not required to be in a rural HPSA or non-MSA.

An originating site is the location of an eligible Medicare beneficiary at the time the service being furnished via telecommunications system occurs. Originating sites authorized by law are listed below.

The office of a physician or practitioner;
A hospital;
A critical access hospital (CAH);
A rural health clinic (RHC);
A federally qualified health center (FQHC);
A hospital-based or critical access hospital-based renal dialysis center (including satellites) (Effective January 1, 2009.);
A skilled nursing facility (SNF) (Effective January 1, 2009.);
A community mental health center (CMHC) (Effective January 1, 2009.).

NOTE: Independent renal dialysis facilities are not eligible originating sites.

270.2 – List of Medicare Telehealth Services

(Rev.178, Issued: 12-30-13; Effective: 1-1-14, Implementation: 1-6-14)

The use of a telecommunications system may substitute for an 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)

Telehealth consultations, emergency department or initial inpatient (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 (Effective March 1, 2003)

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)

Smoking Cessation Services (Effective January 1, 2012)

Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services (Effective January 1, 2013)

Annual alcohol misuse screening (Effective January 1, 2013)

Brief face-to-face behavioral counseling for alcohol misuse (Effective January 1, 2013).

Annual Depression Screening (Effective January 1, 2013)

High-intensity behavioral counseling to prevent sexually transmitted infections (Effective January 1, 2013)

Annual, face-to-face Intensive behavioral therapy for cardiovascular disease (Effective January 1, 2013)

Face-to-face behavioral counseling for obesity (Effective January 1, 2013)

Transitional Care Management Services (Effective January 1, 2014)

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.