CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 97	**Date: November 14, 2008**
	Change Request 6215

SUBJECT: Adding Certain Entities as Originating Sites for Payment of Telehealth Services--Section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

I. SUMMARY OF CHANGES: Section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended Section 1834(m) of the Social Security Act ("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 will also include a hospital-based or critical access hospital-based renal dialysis facility (including satellites); a skilled nursing facility; and a community mental health center.

New / Revised Material
Effective Date: January 1, 2009
Implementation Date: January 5, 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/Telehealth Services
R	15/270/270.1/Eligibility Criteria
R	15/270/270.4.1/Payment for ESRD-Related Services as a Telehealth Service
R	15/270/270.5/Originating Site Facility Fee Payment Methodology

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: 97	Date: November 14, 2008	Change Request: 6215

SUBJECT: Adding Certain Entities as Originating Sites for Payment of Telehealth Services--Section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

Effective Date: **January 1, 2009**

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background: Section 149 of MIPPA amended §1834(m) of the Social Security Act ("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).

B. Policy: For dates of service on or after January 1, 2009, originating sites for Medicare telehealth services will include the office of a physician or practitioner; a hospital; a critical access hospital (CAH); a rural health clinic; a federally qualified health center; a hospital-based or CAH-based renal dialysis facility (including satellites); a skilled nursing facility (SNF); and a community mental health center (CMHC). Consistent with existing statutory requirements, these additional entities must be located in either a non-MSA county or rural HPSA. An interactive audio and video telecommunications system must be used permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit. The only exception to the interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In this circumstance, Medicare payment is permitted for telehealth service when asynchronous store and forward technology is used. 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.

Hospital-based or CAH-based Renal Dialysis Centers

For dates of service on or after January 1, 2009, hospital-based and CAH-based renal dialysis centers (including satellites) are eligible for Medicare payment when they serve as originating sites for telehealth services. The originating site facility fee is covered in addition to the composite rate or MCP amount, and it is a separately billable Part B payment. With respect to the originating site facility fee, hospital-based and CAH-based renal dialysis centers will bill their regular FI or Part A MAC for the originating site facility fee on type of bill (TOB) 72x using revenue code 078X and Healthcare Common Procedure Coding System (HCPCS) code Q3014. Independent renal dialysis facilities are not defined in the law as originating sites and therefore are ineligible to receive payment of the telehealth originating site facility fee.

SNFs

For dates of service on or after January 1, 2009, SNFs as defined in 1819(a) of the Act are eligible for Medicare payment when they serve as originating sites for telehealth services. The originating site facility fee is outside

the SNF prospective payment system bundle and, as such, is not subject to SNF consolidated billing. It is a separately billable Part B payment. With respect to the originating site facility fee, SNFs will bill their regular FI or Part A MAC for the originating site facility fee on TOBs 22x and 23x using revenue code 078X and HCPCS code Q3014.

CMHCs

For dates of service on or after January 1, 2009, CMHCs as defined in 1861(ff)(3)(B) of the Act are eligible for Medicare payment when they serve as originating sites for telehealth services. The originating site facility fee is not bundled in the per diem payment, and it is a separately billable Part B payment. With respect to the originating site facility fee, CMHCs will bill their regular FI or Part A MAC for the originating site facility fee on TOB 76x using revenue code 078X and HCPCS code Q3014. Note that Q3014 does not count towards the number of services used to determine per diem payments for partial hospitalization services.

NOTE: The details of this implementation are dependent upon publication of the physician fee schedule <u>final rule</u> and may be subject to change based on the rulemaking process.

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	
6215.1	Effective January 1, 2009, FISS shall add a hospital-based renal dialysis facility and a CAH-based renal dialysis facility (TOB 072x) to the list of Medicare telehealth originating sites.						X				
6215.1.1	For TOB 72x, the OSCAR number associated with the NPI on the claim must be in the 2300-2499, 3500-3699 or 3700-3799 ranges.						X				
6215.1.2	Effective January 1, 2009, local FIs and/or Part A MACs shall pay for the Medicare telehealth originating site facility fee as described by HCPCS code Q3014 when billed by a hospital-based or CAH-based renal dialysis facility (including satellites) on TOB 72x using revenue code 078x and HCPCS Q3014.	X		X			X				
6215.1.3	The FISS shall not count the originating site facility fee (HCPCS Q3014) in determining the Medicare payment for ESRD services. **NOTE:** The originating site facility fees are not ESRD services and do not count towards the number of services used to determine payment for ESRD services.						X				
6215.2	Effective January 1, 2009, FISS shall add a SNF (TOBs 22x and 23x) to the list of Medicare telehealth originating sites.						X				
6215.2.1	Effective January 1, 2009, Medicare systems shall permit on TOB 22x, HCPCS code Q3014 for a beneficiary in a						X			X	

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	
	covered Part A stay.										
6215.2.2	Effective January 1, 2009, local FIs and/or Part A MACs shall pay for the Medicare telehealth originating site facility fee as described by HCPCS code Q3014 when billed by a SNF on TOB 22x or 23x using revenue code 078x and HCPCS Q3014.	X		X			X				
6215.2.3	CWF shall exclude HCPCS Q3014 from edits enforcing SNF consolidated billing.									X	
6215.3	Effective January 1, 2009, FISS shall add a CMHC (TOB 76x) to the list of Medicare telehealth originating sites.						X				
6215.3.1	Effective January 1, 2009, local FIs and/or Part A MACs shall pay for the Medicare telehealth originating site facility fee as described by HCPCS code Q3014 when billed by a CMHC on TOB 76x using revenue code 078x and HCPCS Q3014.	X		X			X				
6215.3.2	The IOCE shall not count the originating site facility fee (HCPCS Q3014) towards the count of partial hospitalization services used to determine the per diem payment. **NOTE:** The originating site facility fees are not partial hospitalization services and do not count towards the number of services used to determine payment for partial hospitalization services.										IOCE
6215.4	FISS, FIs and Part A MACs shall allow revenue code 078x on TOBs 22x, 23x, 72x and 76x.	X		X			X				
6215.4.1	FISS, FIs and Part A MACs shall allow HCPCS code Q3014 on TOBs 22x, 23x, 72x and 76x.	X		X			X				
6215.5	FISS shall apply any applicable deductible and coinsurance to all telehealth originating site facility fees regardless of TOB.						X				
6215.6	Medicare contractors shall use the following Remittance Advice (RA) Remark Code when denying non-covered charges: N428 – Service/procedure not covered when performed in this place of service.	X		X							
6215.7	Medicare contractors shall use the following Group Code when denying non-covered charges: CO – Provider Liability	X		X							
6215.8	Medicare contractors shall use the following Claim Adjustment Reason Code when denying noncovered charges:	X		X							

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	
	96 – Non-covered Charges										

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	
6215.9	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							

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:

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: 410-786-4595

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 - Telehealth Services

(Rev.97, Issued: 11-14-08, Effective: 01-01-09, Implementation: 01-05-09)

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. Eligible geographic areas include rural health professional shortage areas 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.

270.1 - Eligibility Criteria

(Rev.97, Issued: 11-14-08, Effective: 01-01-09, Implementation: 01-05-09)

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 a*n* MSA.

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.*

270.4.1 – Payment for ESRD-Related Services as a Telehealth Service

(Rev.97, Issued: 11-14-08, Effective: 01-01-09, Implementation: 01-05-09)

The ESRD-related services included in the monthly capitation payment (MCP) with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month may be paid as Medicare telehealth services. However, at least 1 visit must be furnished face-to-face “hands on” to examine the vascular access site by a physician, clinical nurse specialist, nurse practitioner, or physicians assistant. An interactive audio and video

telecommunications system may be used for providing additional visits required under the 2-to-3 visit MCP and the 4-or-more visit MCP. The medical record must indicate that at least one of the visits was furnished face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner, or physician assistant.

The MCP physician, for example, the physician or practitioner who is responsible for the complete monthly assessment of the patient and establishes the patient's plan of care, may use other physicians and practitioners to furnish ESRD-related visits through an interactive audio and video telecommunications system. The non-MCP physician or practitioner must have a relationship with the billing physician or practitioner such as a partner, employees of the same group practice or an employee of the MCP physician, for example, the non MCP physician or practitioner is either a W-2 employee or 1099 independent contractor. However, the physician or practitioner who is responsible for the complete monthly assessment and establishes the ESRD beneficiary's plan of care should bill for the MCP in any given month.

Clinical Criteria

The visit including a clinical examination of the vascular access site must be conducted face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner or physician's assistant. For additional visits, the physician or practitioner at the distant site is required, at a minimum, to use an interactive audio and video telecommunications system that allows the physician or practitioner to provide medical management services for a maintenance dialysis beneficiary. For example, an ESRD-related visit conducted via telecommunications system must permit the physician or practitioner at the distant site to perform an assessment of whether the dialysis is working effectively and whether the patient is tolerating the procedure well (physiologically and psychologically). During this assessment, the physician or practitioner at the distant site must be able to determine whether alteration in any aspect of the beneficiary's prescription is indicated, due to such changes as the estimate of the patient's dry weight.

270.5 - Originating Site Facility Fee Payment Methodology

(Rev.97, Issued: 11-14-08, Effective: 01-01-09, Implementation: 01-05-09)

The term originating site means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii. *The originating site facility fee is a separately billable Part B payment. The contractor pays it outside of other payment methodologies. This fee is subject to post payment verification.*

For telehealth services furnished from October 1, 2001, through December 31, 2002, the originating site facility fee is the lesser of $20 or the actual charge. For services furnished on or after January 1 of each subsequent year, *the originating site facility fee is updated by the* Medicare Economic Index. *The updated fee is included in the Medicare*

Physician Fee Schedule (MPFS) Final Rule, which is published by November 1 prior to the start of the calendar year for which it is effective.

The originating site facility fee is a separately billable Part B payment. The payment amount to the originating site is the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee, except CAHs. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.

The originating site facility fee payment methodology for each type of facility is clarified below:

When the originating site is a hospital outpatient department, payment for the originating site facility fee must be made as described above and not under the outpatient prospective payment system *(OPPS)*. Payment is not based on *the OPPS* payment methodolog*y.*

For hospital inpatients, payment for the originating site facility fee must be made outside the diagnostic related group (DRG) payment since this is a Part B benefit, similar to other services paid separately from the DRG payment.

When the originating site is a critical access hospital, contractors make payment separately from the cost-based reimbursement methodology. *For CAH's, the payment amount is 80 percent of the originating site facility fee.*

The originating site facility fee for telehealth services is not a*n* FQHC and RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.

When the originating site is a physician's or practitioner's office, the payment amount, in accordance with the law, is the lesser of 80 percent of the actual charge or *80 percent of the* originating site facility fee regardless of geographic location. The geographic cost index (GPCI) should not be applied to the originating site facility fee. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the *MPFS*.

When a hospital-based or critical access hospital-based renal dialysis center (or their satellites) serves as the originating site, the originating site facility fee is covered in addition to any composite rate or MCP amount.

The originating site facility fee is outside the SNF prospective payment system bundle and, as such, is not subject to SNF consolidated billing. The originating site facility fee is a separately billable Part B payment.

When a CMHC serves as an originating site, the originating site facility fee is not a partial hospitalization service. The originating site facility fee does not count towards the number of services used to determine payment for partial hospitalization

services. The originating site facility fee is not bundled in the per diem payment for partial hospitalization. The originating site facility fee is a separately billable Part B payment.