CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 99	**Date: DECEMBER 24, 2008**
	Change Request 6130

SUBJECT: Expansion of Medicare Telehealth Services

I. SUMMARY OF CHANGES: In the calendar year 2009 physician fee schedule final rule with comment period (CMS-1403-FC), CMS added three codes to the list of Medicare distant site health services for follow-up inpatient telehealth consultations. These new codes are included in the CY 2009 HCPCS annual update. This CR adds the relevant policy instructions to the manuals, as finalized in the regulation.

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/Table of Contents
R	15/270/270.2/List of Medicare Telehealth Services
N	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: 99	Date: December 24, 2008	Change Request: 6130

SUBJECT: Expansion of Medicare Telehealth Services

Effective Date: January 1, 2009
Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background: In the calendar year 2009 physician fee schedule final rule with comment period (CMS-1403-FC), CMS added three codes to the list of Medicare distant site health services for follow-up inpatient telehealth consultations. These new codes are included in the CY 2009 HCPCS annual update. This CR adds the relevant policy instructions to the manuals, as finalized in the regulation.

B. Policy: CMS created HCPCS codes specific to the telehealth delivery of follow up inpatient consultations to re-establish the ability for practitioners to provide and bill for follow up inpatient consultations delivered via telehealth. The HCPCS codes are limited to the range of services included in the scope of previously deleted CPT codes for follow-up inpatient consultations, and the descriptions limit the use of such services for telehealth. The HCPCS codes clearly designate these services as follow up inpatient consultations provided via telehealth, and not subsequent hospital care used for inpatient visits. These codes are intended for use by practitioners serving beneficiaries located at qualifying originating sites requiring the consultative input of physicians who are not available for an in-person (face-to–face) encounter. These codes are not intended to be used to bill for the ongoing evaluation and management of a hospital inpatient.

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, these 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	
6130.1	Effective January 1, 2009, local Part B carriers and/or A/B MACs shall pay for HCPCS codes G0406, G0407, and G0408 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier.	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	
	NOTE: The type of service for G0406, G0407, and G0408 is 3 (consultation).										
6130.2	Effective January 1, 2009, local FIs and/or A/B MACs shall pay for HCPCS codes G0406, G0407, and G0408 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. **NOTE:** The type of service for G0406, G0407, and G0408 is 3 (consultation).	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	
6130.3	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: 410-786-4595
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.

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

Table of Contents

(Rev. 99, 12-24-08)

270.2 – List of Medicare Telehealth Services

(Rev. 99; Issued: 12-24-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Furnished by CMS

The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultations, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, end stage renal disease related services, and individual medical nutrition therapy. These services are listed below.

Consultations

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)

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

For detailed coding for these services, see Pub.100-04, chapter 12, §190.3.

270.2.1 – Follow-Up Inpatient Telehealth Consultations Defined

(Rev. 99; Issued: 12-24-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Follow-up inpatient telehealth consultations are consultative visits furnished via telehealth to follow up on an initial consultation, or subsequent consultative visits requested by the attending physician. The initial inpatient consultation may have been provided in person or via telehealth.

The conditions of payment for follow-up inpatient telehealth consultations, 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.

Follow-up inpatient telehealth consultations include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the

patient's status or no changes on the consulted health issue. 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.

The physician or practitioner who furnishes the inpatient follow-up consultation via telehealth cannot be the physician of record or the attending physician, and the follow-up inpatient consultation would be distinct from the follow-up care provided by the physician of record or the attending physician. If a physician consultant has initiated treatment at an initial consultation and participates thereafter in the patient's ongoing care management, such care would not be included in the definition of a follow-up inpatient consultation and is not appropriate for delivery via telehealth. Follow-up inpatient telehealth consultations are subject to the criteria for consultation services, as described in Pub. 100-04, chapter 12, §30.6.10.

Payment for follow-up inpatient telehealth consultations includes all consultation related services furnished before, during, and after communicating with the patient via telehealth. Pre-service activities would include, but would not be limited to, reviewing patient data (for example, diagnostic and imaging studies, interim labwork) and communicating with other professionals or family members. Key elements of the intra-service activities are taking an interval history, conducting an examination, and engaging in medical decision making. Follow-up inpatient telehealth consultations must include at least two of these three key elements, as described in Pub. 100-04, chapter 12, §190.3.1. Post-service activities would include, but would not be limited to, completing medical records or other documentation and communicating results of the consultation and further care plans to other health care professionals. No additional evaluation and management service could be billed for work related to a follow-up inpatient telehealth consultation.