CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3929	**Date: November 29, 2017**
	Change Request 10152

Transmittal 3817, dated July 28, 2017, is being rescinded and replaced by Transmittal 3929, dated, November 29, 2017 to add a business requirement stating, "The Multi-Carrier System Desktop Tool (MCSDT) shall display telehealth service information in a format equivalent to the updated Telehealth Auxiliary file (TELH) in CWF HIMR." All other information remains the same. Also, please note that as of November 29, 2017 the sensitive/controversial language was removed from the CR.

SUBJECT: Elimination of the GT Modifier for Telehealth Services

I. SUMMARY OF CHANGES: This instruction eliminates the requirement to use the GT modifier (via interactive audio and video telecommunications systems) on professional claims for telehealth services. Use of the telehealth POS code 02 certifies that the service meets the telehealth requirements.

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/190.3.2 Telehealth Consultation Services, Emergency Department or Initial Inpatient Defined
R	12/190.3.3 Follow-Up Inpatient Telehealth Consultations Defined
R	12/190.3.6 Payment for Diabetes Self-Management Training (DSMT) as a Telehealth Service
R	12/190.6.1 Submission of Telehealth Claims for Distant Site Practitioners
R	12/190.7 A/B MAC (B) Editing of Telehealth Claims

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 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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3929	Date: November 29, 2017	Change Request: 10152

Transmittal 3817, dated July 28, 2017, is being rescinded and replaced by Transmittal 3929, dated, November 29, 2017 to add a business requirement stating, "The Multi-Carrier System Desktop Tool (MCSDT) shall display telehealth service information in a format equivalent to the updated Telehealth Auxiliary file (TELH) in CWF HIMR." All other information remains the same. Also, please note that as of November 29, 2017 the sensitive/controversial language was removed from the CR.

SUBJECT: Elimination of the GT Modifier for Telehealth Services

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

I. GENERAL INFORMATION

A. Background: Previous guidance instructed practitioners to submit claims for telehealth services using the appropriate procedure code for the professional service along with the telehealth modifier GT (via interactive audio and video telecommunications systems). In the CY 2017 Physician Fee Schedule (PFS) final rule, payment policies regarding Medicare's use of a new Place of Service (POS) Code describing services furnished via telehealth (POS 02) were finalized and implemented through CR 9726. The new POS code became effective January 1, 2017. The CY 2017 PFS final rule noted that like the modifiers, use of the telehealth POS code certifies that the service meets the telehealth requirements.

B. Policy: Effective January 1, 2018, the requirement to use the GT modifier on professional claims for telehealth services has been eliminated. Use of the telehealth POS code 02 certifies that the service meets the telehealth requirements (via interactive audio and video telecommunications systems). The GQ modifier is still required when applicable.

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	
10152.1	Contractors shall no longer require the GT modifier to be billed along with Place of Service (POS) 02 on professional claims for telehealth services.		X							
10152.2	Contractors shall be aware that for distant site services billed under Critical Access Hospital (CAH) method II on institutional claims, the GT modifier will still be required.	X								
10152.3	Contractors shall apply the existing "one every three		X						X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	days" frequency edit logic for telehealth services when codes 99231, 99232, and 99233 are billed with POS 02 for claims with dates of service January 1, 2018, and after. **NOTE:** The frequency editing also applies when these services are span-dated on the claim (i.e., the "from" date and the "to" date of service are not equal, and the "units" field is greater than one).									
10152.4	Contractors shall apply the existing "one every 30 days" frequency edit logic for telehealth services when codes 99307, 99308, 99309, and 99310 are billed with POS 02 for claims with dates of service January 1, 2018, and after. **NOTE:** The frequency editing also applies when these services are span-dated on the claim (i.e., the "from" date and the "to" date of service are not equal, and the "units" field is greater than one).		X						X	
10152.5	Contractors shall include POS '02' in the informational message (Rule Code) for the Next Eligible Date applications for PRVN in HIMR, Provider Inquiry, HUQA, and MBD/NGD for the Telehealth Services.								X	MBD, NGD
10152.6	Contractors shall be aware of changes to the Medicare Claims Processing Manual, Pub. 100-04, Ch. 12, Section 190, Submission of Telehealth Claims for Distant Site Practitioners, contained in this change request.	X	X							
10152.7	The Multi-Carrier System Desktop Tool (MCSDT) shall display telehealth service information in a format equivalent to the updated Telehealth Auxiliary file (TELH) in CWF HIMR.						X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
10152.8	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 5 business days after receipt of the notification from CMS announcing the availability of the 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): Yvette Cousar, yvette.cousar@cms.hhs.gov , Tracey Mackey, tracey.mackey@cms.hhs.gov , Lindsey Baldwin, lindsey.baldwin@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

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.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

190.3.2 - Telehealth Consultation Services, Emergency Department or Initial Inpatient Defined
(Rev.3929; Issued: 11-29-17; Effective: 01-01-18; Implementation: 01-02-18)

Emergency department or initial inpatient telehealth consultations are furnished to beneficiaries in hospitals or SNFs via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the emergency department or initial inpatient consultation via telehealth cannot be the physician of record or the attending physician, and the emergency department or initial inpatient telehealth consultation would be distinct from the care provided by the physician of record or the attending physician. 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.
Emergency department or initial inpatient telehealth consultations are subject to the criteria for emergency department or initial inpatient telehealth consultation services, as described in section 190.3.1 of this chapter.
Payment for emergency department or initial 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. Intra-service activities must include the three key elements described below for each procedure code. 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 E/M service could be billed for work related to an emergency department or initial inpatient telehealth consultation.
Emergency department or initial inpatient telehealth consultations could be provided at various levels of complexity:

- Practitioners taking a problem focused history, conducting a problem focused examination, and engaging in medical decision making that is straightforward, would bill HCPCS code G0425 (Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth).

- Practitioners taking a detailed history, conducting a detailed examination, and engaging in medical decision making that is of moderate complexity, would bill HCPCS code G0426 (Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth).

- Practitioners taking a comprehensive history, conducting a comprehensive examination, and engaging in medical decision making that is of high complexity, would bill HCPCS code G0427 (Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth).

Although emergency department or initial inpatient telehealth consultations are specific to telehealth, these services must be billed with *POS 02* to identify the telehealth technology used to provide the service.

190.3.3 - Follow-Up Inpatient Telehealth Consultations Defined
(Rev.3929; Issued: 11-29-17; Effective: 01-01-18; Implementation: 01-02-18)

Follow-up inpatient telehealth consultations are furnished to beneficiaries in hospitals or SNFs 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.

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. Follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in section 190.3.1 of this chapter.
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. Intra-service activities must include at least two of the three key elements described below for each procedure code. 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.
Follow-up inpatient telehealth consultations could be provided at various levels of complexity:

- Practitioners taking a problem focused interval history, conducting a problem focused examination, and engaging in medical decision making that is straightforward or of low complexity, would bill a limited service, using HCPCS code G0406 (Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth).

- Practitioners taking an expanded focused interval history, conducting an expanded problem focused examination, and engaging in medical decision making that is of moderate complexity, would bill an intermediate service using HCPCS code G0407(Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth).

- Practitioners taking a detailed interval history, conducting a detailed examination, and engaging in medical decision making that is of high complexity, would bill a complex service, using HCPCS code G0408 (Follow-up inpatient telehealth consultation, complex, physicians typically spend 35 minutes or more communicating with the patient via telehealth).

Although follow-up inpatient telehealth consultations are specific to telehealth, these services must be billed with *POS 02* to identify the telehealth technology used to provide the service.

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

(Rev.3929; Issued: 11-29-17; Effective: 01-01-18; Implementation: 01-02-18)

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 *POS 02* with HCPCS code G0108 (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 Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 300.2, 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 190.6 of this chapter, Medicare telehealth services, including individual DSMT services furnished as a telehealth service, could only be furnished by a licensed PA, NP, CNS, CNM , clinical psychologist, clinical social worker, or registered dietitian or nutrition professional.

190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners

(Rev.3929; Issued: 11-29-17; Effective: 01-01-18; Implementation: 01-02-18)

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 with place of service code 02 (Telehealth). By billing *place of service code 02* 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 billing the *place of service code 02* 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 section 190.3.4 of this chapter 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, *CAHs submit the appropriate HCPCS procedure code for the covered telehealth services with the GT modifier, and* A/B/MACs (A) should make payment for telehealth services provided by the physician or practitioner at 80 percent of the MPFS facility amount for the distant site service. In all other cases, except for MNT services as discussed in Section 190.7- A/B MAC (B) Editing of Telehealth Claims, telehealth services provided by the physician or practitioner at the distant site are billed to the A/B/MAC (B).
Physicians and practitioners at the distant site bill their A/B/MAC (B) for covered telehealth services. Physicians' and practitioners' offices serving as a telehealth originating site bill their A/B/MAC (B) for the originating site facility fee.

190.7 - A/B MAC (B) Editing of Telehealth Claims

(Rev.3929; Issued: 11-29-17; Effective: 01-01-18; Implementation: 01-02-18)

Medicare telehealth services (as listed in section 190.3) are billed with *POS 02*. The contractor shall approve covered telehealth services if the physician or practitioner is licensed under State law to provide the service. Contractors must familiarize themselves with licensure provisions of States for which they process claims and disallow telehealth services furnished by physicians or practitioners who are not authorized to furnish the applicable telehealth service under State law. For example, if a nurse practitioner is not licensed to provide individual psychotherapy under State law, he or she would not be permitted to receive payment for individual psychotherapy under Medicare. The contractor shall install edits to ensure that only properly licensed physicians and practitioners are paid for covered telehealth services.
If a contractor receives claims for professional telehealth services coded with the "GQ" modifier (representing "via asynchronous telecommunications system"), it shall approve/pay for these services only if the physician or practitioner is affiliated with a Federal telemedicine demonstration conducted in Alaska or Hawaii. The contractor may require the physician or practitioner at the distant site to document his or her participation in a Federal telemedicine demonstration program conducted in Alaska or Hawaii prior to paying for telehealth services provided via asynchronous, store and forward technologies.
Contractors shall deny telehealth services if the physician or practitioner is not eligible to bill for them.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.
Group Code: CO
CARC: 185

RARC: N/A
MSN: 21.18

If a service is billed with *POS 02* and the procedure code is not designated as a covered telehealth service, the contractor denies the service.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: 96
RARC: N776
MSN: 9.4

The only claims from institutional facilities that FIs shall pay for telehealth services at the distant site, except for MNT services, are for physician or practitioner services when the distant site is located in a CAH that has elected Method II, and the physician or practitioner has reassigned his/her benefits to the CAH. The CAH bills its regular FI for the professional services provided at the distant site via a telecommunications system, in any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply.

Claims from hospitals or CAHs for MNT services are submitted to the hospital's or CAH's regular FI. Payment is based on the non-facility amount on the Medicare Physician Fee Schedule for the particular HCPCS codes.