CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4026	**Date: April 27, 2018**
	Change Request 10583

SUBJECT: Revisions to the Telehealth Billing Requirements for Distant Site Services

I. SUMMARY OF CHANGES: This Change Request (CR) implements requirement for billing modifier GT for Telehealth Distant Site Services.

EFFECTIVE DATE: October 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 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
N/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 4026	Date: April 27, 2018	Change Request: 10583

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I. GENERAL INFORMATION

A. Background: Previous guidance instructed providers to submit claims for telehealth services using the appropriate procedure code along with the telehealth modifier GT (via interactive audio and video telecommunications systems). In the Calendar Year (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. In the CY 2018 PFS final rule, the requirement to use the GT modifier was eliminated for all professional claims. CR 10152, which implemented that policy, included a business requirement instructing contractors to be aware that the GT modifier would still be required for distant site services billed under Critical Access Hospital (CAH) Method II on institutional claims.

B. Policy: As of October 1, 2018, the GT modifier is only allowed on institutional claims billed under CAH Method II.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10583.1	Contractors shall create a line level reason code to reject any service line(s) that contains a modifier 'GT', except when: • the type of bill is a CAH method II with revenue code 96X, 97X, or 98X; or • the service line contains Healthcare Common Procedure Coding System (HCPCS) code Q3014.					X				
10583.2	Contractors shall reject the line with the following:	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Group Code CO - Contractual obligation CARC 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 07/01/2017 RARC N519 - Invalid combination of HCPCS modifiers. MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10583.3	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 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:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Lindsey Baldwin, 410-786-1694 or 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):
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ATTACHMENTS: 0