CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1881	**Date: DECEMBER 18, 2009**
	Change Request 6705

SUBJECT: Expansion of Medicare Telehealth Services for CY 2010

I. SUMMARY OF CHANGES: In the calendar year 2010 physician fee schedule final rule with comment period (CMS-1413-FC), CMS added three codes to the list of Medicare distant site health services for individual health and behavior assessment and intervention (HBAI) services and three codes for initial inpatient telehealth consultations. CMS also expanded the definition of follow-up inpatient telehealth consultations to include consultative visits furnished via telehealth to beneficiaries in hospitals or SNFs. These codes are included in the CY 2010 HCPCS annual update. This CR adds the relevant policy instructions to the manuals, as finalized in the regulations.

Note: The information contained in section 190.3.3 was previously in section 190.3.1 and has been reorganized.

New / Revised Material
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

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	12/Table of Contents
R	12/190/190.3/List of Medicare Telehealth Services
R	12/190/190.3.1/Inpatient Telehealth Consultation Services versus Inpatient Evaluation and Management (E/M) Visits
N	12/190/190.3.2/Initial Inpatient Telehealth Consultations Defined
N	12/190/190.3.3/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. 100-04	Transmittal: 1881	Date: December 18, 2009	Change Request: 6705

SUBJECT: Expansion of Medicare Telehealth Services for CY 2010

Effective Date: January 1, 2010
Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A. Background: In the calendar year 2010 physician fee schedule final rule with comment period (CMS-1413-FC), CMS added three codes to the list of Medicare distant site telehealth services for individual health and behavior assessment and intervention (HBAI) services and three codes for initial inpatient telehealth consultations. CMS also expanded the definition of follow-up inpatient telehealth consultations to include consultative visits furnished via telehealth to beneficiaries in SNFs. These codes are included in the CY 2010 HCPCS annual update. This CR adds the relevant policy instructions to the manuals, as finalized in the regulations.

B. Policy: The list of Medicare telehealth services was expanded to include individual HBAI, as described by HCPCS codes 96150-96152, and initial inpatient telehealth consultations, as described by HCPCS codes G0425-G0427. Effective January 1, 2010, the telehealth modifier “GT” (via interactive audio and video telecommunications system) and modifier “GQ” (via asynchronous telecommunications system) are valid when billed with these HCPCS codes. In addition, effective January 1, 2010, follow-up inpatient telehealth consultations, as described by HCPCS codes G0406-G0408, are valid when billed for services furnished to beneficiaries in hospitals or SNFs.

Effective January 1, 2010, CMS eliminated the use of all consultation CPT codes. CMS will issue a separate change request to address the revisions in consultation services payment policy. Because revisions in consultation services payment policy affect telehealth policy, this change request includes references to the revisions relevant to professional consultations furnished via telehealth.

As a result of this change to the use of consultation CPT codes, CMS will no longer recognize office/outpatient consultation CPT codes 99241-99245. Instead, physicians and practitioners are instructed to bill a new or established patient visit CPT code (in the range of CPT codes 99201-99215), as appropriate to the particular patient, for all office/outpatient visits furnished via telehealth. CMS will no longer recognize initial inpatient consultation CPT codes 99251-99255. Instead, CMS created HCPCS codes G0425-G0427 specific to the telehealth delivery of initial inpatient consultations to retain the ability for practitioners to furnish and bill for initial inpatient consultations delivered via telehealth.

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, all telehealth 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	
6705.1	Effective January 1, 2010, Medicare contractors shall pay for HCPCS codes 96150-96152 and G0425-G0427 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier. **NOTE:** The type of service for G0425-G0427 is 3 (consultation). Also, codes G0425-G0427 are included in the CY 2010 HCPCS annual update.	X			X						
6705.2	Effective January 1, 2010, Medicare contractors shall pay follow-up inpatient telehealth consultation codes G0406-G0408 with the GT or GQ modifier when billed with place of service (POS) inpatient hospital or skilled nursing facility (SNF). **NOTE:** These codes were effective January 1, 2009, and were only valid for POS inpatient hospital; they now have been expanded to include POS SNF.	X			X						
6705.3	Effective January 1, 2010, Medicare contractors shall pay initial inpatient telehealth consultation codes G0425-G0427 with the GT or GQ modifier when billed with POS inpatient hospital or skilled nursing facility (SNF).	X			X						
6705.4	Effective January 1, 2010, Medicare contractors shall pay for HCPCS codes 96150-96152 and G0425-G0427 when submitted with a GT or GQ modifier, by CAHs that have elected Method II on TOB 85x.	X		X							
6705.5	Medicare contractors shall remove codes 99241 through 99255 from the list of telehealth services for dates of service on or after January 1, 2010. These codes were discontinued with the 2010 HCPCS update.	X		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	
6705.6	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: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Policy: Gail Addis: Gail.Addis@cms.hhs.gov: 410-786-4522
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 Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

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(Rev. 1881, 12-18-09)

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190.3 - List of Medicare Telehealth Services

(Rev. 1881; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for *professional* consultation*s*, office visits, *office psychiatry services, and a limited number of other physician fee schedule (PFS) services. The various* services and corresponding current procedure terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes are listed below.

- Consultations (CPT codes 99241 - 99275) - Effective October 1, 2001 – December 31, 2005;

- Consultations (CPT codes 99241 - 99255) - Effective January 1, 2006 *– December 31, 2009;*

- *Initial inpatient telehealth consultations (HCPCS codes G0425 – G0427) - Effective January 1, 2010;*

- *Follow-up inpatient telehealth consultations (HCPCS codes G0406, G0407, and G0408) - Effective January 1, 2009;*

- Office or other outpatient visits (CPT codes 99201 - 99215);

- Individual psychotherapy (CPT codes 90804 - 90809);

- Pharmacologic management (CPT code 90862);

- Psychiatric diagnostic interview examination (CPT code 90801) – Effective March 1, 2003;

- End Stage Renal Disease (ESRD) related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) – Effective January 1, 2005 – December 31, 2008;

- End Stage Renal Disease (ESRD) related services (CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961) – Effective January 1, 2009;

- Individual Medical Nutrition Therapy (HCPCS codes G0270, 97802, and 97803) - Effective January 1, 2006;

- Neurobehavioral status exam (CPT code 96116) - Effective January 1, 2008; *and*

- *Individual health and behavior assessment and intervention (CPT codes 96150 – 96152) - Effective January 1, 2010.*

NOTE: *Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS will no longer recognize office/outpatient consultation CPT codes for payment of office/outpatient visits. Instead, physicians and practitioners are instructed to bill a new or established patient visit CPT code (in the range of CPT codes 99201-99215), as appropriate to the particular patient, for all office/outpatient visits.*

190.3.1 - *Inpatient Telehealth Consultation Services versus Inpatient Evaluation and Management (E/M) Visits*

(Rev. 1881; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

A consultation service is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). It can involve an opinion, advice, recommendation, suggestion, direction, or counsel from a physician or qualified nonphysician practitioner (NPP) at the request of another physician or appropriate source.

Section 1834(m) of the Social Security Act includes "professional consultations" in the definition of telehealth services. Inpatient consultations furnished via telehealth can facilitate the provision of certain services and/or medical expertise that might not otherwise be available to a patient located at an originating site.

The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for initial and follow-up inpatient consultations. E/M inpatient visits may not be furnished via telehealth.

Medicare contractors pay for reasonable and medically necessary inpatient telehealth consultation services furnished to beneficiaries in hospitals or SNFs when all of the following criteria for the use of a consultation code are met:

- *An inpatient consultation service is distinguished from other inpatient evaluation and management (E/M) visits because it is provided by a physician or qualified NPP whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The qualified NPP may perform consultation services within the scope of practice and licensure requirements for NPPs in the State in which he/she practices;*

- *A request for an inpatient telehealth consultation from an appropriate source and the need for an inpatient telehealth consultation (i.e., the reason for a consultation service) shall be documented by the consultant in the patient's medical record and included in the requesting physician or qualified NPP's plan of care in the patient's medical record; and*

- *After the inpatient telehealth consultation is provided, the consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician.*

The intent of an inpatient telehealth consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge.

190.3.2 - Initial Inpatient Telehealth Consultations Defined

(Rev. 1881; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

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 initial inpatient consultation via telehealth cannot be the physician of record or the attending physician, and the 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. Initial inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in §190.3.1.

Payment for 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 initial inpatient telehealth consultation.

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 G0425. At this level of service, practitioners would typically spend 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 G0426. At this level of service, practitioners would typically spend 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 G0427. At this level of service, practitioners would typically spend 70 minutes or more communicating with the patient via telehealth.*

Although initial inpatient telehealth consultations are specific to telehealth, these services must be billed with either the "GT" or "GQ" modifier to identify the telehealth technology used to provide the service. (See §190.6 et. al. for instructions on how to use these modifiers.)

190.3.3 - Follow-Up Inpatient Telehealth Consultations Defined

(Rev. 1881; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

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 and is not appropriate for delivery via telehealth. Follow-up inpatient telehealth consultations are subject to the criteria for *inpatient telehealth* consultation services, as described in §*190.3.1*

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 G0406, Follow-up inpatient telehealth consultation, limited. At this level of service, practitioners would 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 G0407, Follow-up inpatient telehealth consultation, intermediate. At this level of service, practitioners would 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 G0408, Follow-up inpatient telehealth consultation, complex. At this level of service, practitioners would 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 either the “GT” or “GQ” modifier to identify the telehealth technology used to provide the service. (See §190.6 et. al. for instructions on how to use these modifiers.)