CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2168	**Date: February 28, 2011**
	Change Request 7049

Transmittal 2032, dated August 20, 2010, is being rescinded and replaced by Transmittal 2168, dated February 28, 2011. April 4, 2011 is being added as an implementation date, and FISS is being added as a responsible party for Business Requirement 7049.2. Additionally, a new Business Requirement 7049.3 is added. The Provider Education requirement number is now 7049.4. All other information remains the same.

SUBJECT: Expansion of Medicare Telehealth Services for CY 2011

I. SUMMARY OF CHANGES: CMS has added codes to the list of Medicare Telehealth Services.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011 for A/B MACs and Carriers; April 4, 2011 for A/B MACs and Fiscal Intermediaries

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	12/190.3/List of Medicare Telehealth Services
R	12/190.3.1/Inpatient Telehealth Consultation Services versus Inpatient Evaluation and Management (E/M) Visits
R	12/190.3.2/Initial Inpatient Telehealth Consultations Defined
R	12/190.3.3/Follow-Up Inpatient Telehealth Consultations Defined

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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: 2168	Date: February 28, 2011	Change Request: 7049

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SUBJECT: Expansion of Medicare Telehealth Services for CY 2011

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011 for A/B MACs and Carriers; April 4, 2011 for A/B MACs and Fiscal Intermediaries

I. GENERAL INFORMATION

A. Background: CMS has added 14 codes to the list of Medicare distant site telehealth services for individual and group Kidney Disease Education (KDE) services, individual and group Diabetes Self Management Training (DSMT) services, group Medical Nutrition Therapy (MNT) services, group Health and Behavior Assessment and Intervention (HBAI) services, and subsequent hospital care and nursing facility care services to the list of telehealth services for which payment will be made at the applicable PFS payment amount for the service of the physician or practitioner.

B. **Policy:** CMS is adding the following requested services to the list of Medicare telehealth Services for CY 2011:

- Individual and group KDE services (HCPCS codes G0420 and G0421, respectively);

- Individual and group DSMT services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training (HCPCS codes G0108 and G0109, respectively);

- Group MNT and HBAI services (CPT codes 97804, and 96153 and 96154, respectively);

- Subsequent hospital care services, with the limitation of one telehealth visit every 3 days (CPT codes 99231, 99232, and 99233); and

Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days (CPT codes 99307, 99308, 99309, and 99310).

CMS also limited the use of telehealth in two ways. First, for hospital care services, CMS limited the patient's admitting physician or practitioner to one telehealth visit every 3 days. For subsequent nursing facility care services, CMS limited the patient's admitting physician or non-physician practitioner to one telehealth visit every 30 days. Also, for DSMT, CMS required a minimum of 1 hour of in-person instruction to be furnished in the year following the initial training to ensure effective injection training.

II. BUSINESS REQUIREMENTS 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	
7049.1	For dates of service on or after January 1, 2011, contractors (local Part B carriers and/or A/B MACs) shall accept and pay the following codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ or GT modifier: G0108 – G0109; G0420 – G0421; 96153 – 96154; 97804; 99231 – 99233; 99307 – 99310.	X			X						
7049.2	For dates of service on or after January 1, 2011, contractors (local FIs and/or A/B MACs) shall accept and pay the following codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ or GT modifier by CAHs that have elected Method II on TOB 85X: G0108 – G0109; G0420 – G0421; 96153 – 96154; 97804; 99231 – 99233; 99307 – 99310.	X		X			X				
7049.3	A/B MACs and Fiscal Intermediaries need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention.	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	
7049.4	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: Ryan Howe at ryan.howe@cms.hhs.gov, or 410-786-3355.
Part A claims processing: Tracey Mackey at tracey.mackey@cms.hhs.gov, or 410-786-5736.
Part B claims processing: Kathleen Kersell at kathleen.kersell@cms.hhs.gov, or 410-786-2033.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *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.

190.3 - List of Medicare Telehealth Services

(Rev.2168, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs, Carriers/04-04-11 A/B MACs, FIs)

The use of a telecommunications system may substitute for *an in-person* encounter for professional consultations, 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);
- *Subsequent hospital care services, with the limitation of one telehealth visit every 3 days (CPT codes 99231, 99232, and 99233) – Effective January 1, 2011;*
- *Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days (CPT codes 99307, 99308, 99309, and 99310) – Effective January 1, 2011;*
- Pharmacologic management (CPT code 90862);
- Individual psychotherapy (CPT codes 90804 - 90809); Psychiatric diagnostic interview examination (CPT code 90801) – Effective March 1, 2003;
- Neurobehavioral status exam (CPT code 96116) - Effective January 1, 2008;
- 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 *and group* medical nutrition therapy (HCPCS codes G0270, 97802, 97803, *and 97804) – Individual* effective January 1, 2006; *group effective January 1, 2011;*

- Individual *and group health* and behavior assessment and intervention (CPT codes 96150 – *96154) – Individual* effective January 1, 2010; *group effective January 1, 2011.*

- *Individual and group kidney disease education (KDE) services (HCPCS codes G0420 and G0421) – Effective January 1, 2011; and*

- *Individual and group diabetes self-management training (DSMT) services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training (HCPCS codes G0108 and G0109) - Effective January 1, 2011.*

NOTE: Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer *recognizes* office/outpatient *or inpatient* consultation CPT codes for payment of office/outpatient *or inpatient* visits. Instead, physicians and practitioners are instructed to bill a new or established patient *office/outpatient* visit CPT code *or appropriate hospital or nursing facility care code,* as appropriate to the particular patient, for all office/outpatient *or inpatient* visits.

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

(Rev.2168, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs, Carriers/04-04-11 A/B MACs, FIs)

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 *an in-person* encounter for initial and follow-up inpatient consultations.

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 *nonphysician*

*practitioner (*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.

Unlike inpatient telehealth consultations, the majority of subsequent inpatient hospital and nursing facility care services require in-person visits to facilitate the comprehensive, coordinated, and personal care that medically volatile, acutely ill patients require on an ongoing basis.

Subsequent hospital care services are limited to one telehealth visit every 3 days. Subsequent nursing facility care services are limited to one telehealth visit every 30 days.

190.3.2 - Initial Inpatient Telehealth Consultations Defined

(Rev.2168, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs, Carriers/04-04-11 A/B MACs, FIs)

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 section 190.3.1 *of this chapter*.

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 *code* G0425 *(Initial inpatient telehealth consultation,* 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 *(Initial inpatient telehealth consultation,* 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*(Initial inpatient telehealth consultation,* typically 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 section 190.6 *of this chapter* for instructions on how to use these modifiers.

190.3.3 - Follow-Up Inpatient Telehealth Consultations Defined

(Rev.2168, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs, Carriers/04-04-11 A/B MACs, FIs)

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 either the -GT or -GQ modifier to identify the telehealth technology used to provide the service. (See section 190.6 *of this chapter* for instructions on how to use these modifiers.)