CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2354	**Date: November 18, 2011**
	Change Request 7504

Transmittal 2273, dated August 12, 2011, is being rescinded and replaced by Transmittal 2354, dated November 18, 2011, to amend Business Requirement 7504-04.3 and the corresponding manual instructions to conform to final policies regarding emergency room telehealth consultations in the CY 2012 Physician Fee Schedule Final Rule. This CR is no longer Sensitive and may now be posted to the Internet. All other information remains the same.

SUBJECT: Expansion of Medicare Telehealth Services for CY 2012

I. SUMMARY OF CHANGES: This CR adds relevant policy instructions to the manuals regarding the addition of these codes and language regarding the recurring CR used to update the annual telehealth originating site facility fee.

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: January 3, 2012

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/Telehealth Consultation Services, Emergency Department or Initial Inpatient versus Inpatient Evaluation and Management (E/M) Visits
R	12/190.3.2/Telehealth Consultation Services, Emergency Department or Initial Inpatient Defined
R	12/190.6/Originating Site Facility Fee Payment Methodology

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
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: 2354	Date: November 18, 2011	Change Request: 7504

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SUBJECT: Expansion of Medicare Telehealth Services for CY 2012

EFFECTIVE DATE: January 1, 2012
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I. GENERAL INFORMATION

Background: In the calendar year 2012 physician fee schedule proposed rule with comment period, CMS is proposing to add 4 codes to the list of Medicare distant site telehealth services. These codes are for smoking cessation services. This CR also adds relevant policy instructions to the manuals.

Policy: CMS is adding Smoking Cessation services to the list of Medicare telehealth Services for CY 2012. The following CPT and HCPCS codes should be added to the list of Medicare Telehealth Services:

- CPT codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes), and

- HCPCS codes G0436 (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes) and G0437 (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes).

This CR also adds relevant policy instructions to the manuals regarding the addition of these codes and language regarding the recurring CR used to update the annual telehealth originating site facility fee.

CMS is also allowing initial inpatient telehealth consultation codes G0425-G0427 to be billed with the place of service (POS) emergency department.

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	
7504-04.1	For dates of service on or after January 1, 2012, 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: 99406 – 99407; G0436 – G0437.	X			X						
7504-04.2	For dates of service on or after January 1, 2012, 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: 99406 – 99407; G0436 – G0437.	X		X			X				
7504-04.3	Effective January 1, 2012, Medicare contractors shall pay initial inpatient telehealth consultation codes G0425-G0427 with the GT or GQ modifier when billed with place of service (POS) emergency department in addition to inpatient hospital or skilled nursing facility (SNF). (The code descriptors for these codes will change at that time to include emergency department patients.)	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	
7504-04.4	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: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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, or Chanelle Jones at chanelle.jones@cms.hhs.gov, or (410) 786-9668.

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)*:

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/Nonphysicians Practitioners

Table of Contents
(Rev.2354, Issued: 11-18-11)

190.3 - List of Medicare Telehealth Services

(Rev.2354, Issued: 11-18-11, Effective: 01-01-12, Implementation: 01-03-12)

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;

- *Telehealth consultations, emergency department or initial inpatient* (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.

- *Smoking Cessation Services (CPT codes 99406 and 99407and HCPCS codes G0436 and G0437) – Effective January 1, 2012.*

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 - *Telehealth Consultation Services, Emergency Department or Initial Inpatient* versus Inpatient Evaluation and Management (E/M) Visits

(Rev.2354, Issued:11-18-11 Effective: 01-01-12, Implementation: 01-03-12)

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 *or emergency department* 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 *emergency department or* initial and follow-up inpatient consultations.

Medicare contractors pay for reasonable and medically necessary inpatient *or emergency department* 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 *or emergency department* consultation service is distinguished from other inpatient *or emergency department* 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 *or emergency department* telehealth consultation from an appropriate source and the need for an inpatient *or emergency department* 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 *or emergency department* 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 *or emergency department* 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 *or emergency department* telehealth consultations, the majority of subsequent inpatient hospital*, emergency department* 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 - *Telehealth Consultation Services, Emergency Department or Initial Inpatient* Defined

(Rev. 2354, Issued: 11-18-11, Effective: 01-01-12, Implementation: 01-03-12)

*Emergency department or i*nitial 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 i*nitial 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 i*nitial 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 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.

190.6 - Originating Site Facility Fee Payment Methodology

(Rev.2354, Issued: 11-18-11, Effective: 01-01-12, Implementation: 01-03-12)

1. Originating site defined

The term originating site means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii.

2. Facility fee for originating site

The originating site facility fee is a separately billable Part B payment. The contractor pays it outside of other payment methodologies. This fee is subject to post payment verification.

For telehealth services furnished from October 1, 2001, through December 31, 2002, the originating site facility fee is the lesser of $20 or the actual charge. For services furnished on or after January 1 of each subsequent year, the originating site facility fee is updated by the Medicare Economic Index. The updated fee is included in the Medicare Physician Fee Schedule (MPFS) Final Rule, which is published by November 1 prior to the start of the calendar year for which it is effective. *The updated fee for each calendar year is also issued annually in a Recurring Update Notification instruction for January of each year.*

3. Payment amount:

The originating site facility fee is a separately billable Part B payment. The payment amount to the originating site is the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee, except CAHs. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.

The originating site facility fee payment methodology for each type of facility is clarified below.

Hospital outpatient department. When the originating site is a hospital outpatient department, payment for the originating site facility fee must be made as described above and not under the outpatient prospective payment system (OPPS). Payment is not based on the OPPS payment methodology.

Hospital inpatient. For hospital inpatients, payment for the originating site facility fee must be made outside the diagnostic related group (DRG) payment, since this is a Part B benefit, similar to other services paid separately from the DRG payment, (e.g., hemophilia blood clotting factor).

Critical access hospitals. When the originating site is a critical access hospital, make payment separately from the cost-based reimbursement methodology. For CAH's, the payment amount is 80 percent of the originating site facility fee.

Federally qualified health centers (FQHCs) and rural health clinics (RHCs). The originating site facility fee for telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.

Physicians' and practitioners' offices. When the originating site is a physician's or practitioner's office, the payment amount, in accordance with the law, is the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee, regardless of geographic location. The carrier shall not apply the geographic practice cost index (GPCI) to the originating site facility fee. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the MPFS.

Hospital-based or critical access-hospital based renal dialysis center (or their satellites). When a hospital-based or critical access hospital-based renal dialysis center (or their satellites) serves as the originating site, the originating site facility fee is covered in addition to any composite rate or MCP amount.

Skilled nursing facility (SNF). The originating site facility fee is outside the SNF prospective payment system bundle and, as such, is not subject to SNF consolidated billing. The originating site facility fee is a separately billable Part B payment.

Community Mental Health Center (CMHC). The originating site facility fee is not a partial hospitalization service. The originating site facility fee does not count towards the number of services used to determine payment for partial hospitalization services. The originating site facility fee is not bundled in the per diem payment for partial hospitalization. The originating site facility fee is a separately billable Part B payment.

To receive the originating facility site fee, the provider submits claims with HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." The type of service for the telehealth originating site facility fee is "9, other items and services." For carrier-processed claims, the "office" place of service (code 11) is the only payable setting for code Q3014. There is no participation payment differential for code Q3014. Deductible and coinsurance rules apply to Q3014. By submitting Q3014 HCPCS code, the originating site authenticates they are located in either a rural HPSA or non-MSA county.

This benefit may be billed on bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, and 85X. Unless otherwise applicable, report the originating site facility fee under revenue code 078X and include HCPCS code "Q3014, telehealth originating site facility fee."

Hospitals and critical access hospitals bill their intermediary for the originating site facility fee. Telehealth bills originating in inpatient hospitals must be submitted on a 12X TOB using the date of discharge as the line item date of service.

Independent and provider-based RHCs and FQHCs bill the appropriate intermediary using the RHC or FQHC bill type and billing number. HCPCS code Q3014 is the only non-RHC/FQHC service that is billed using the clinic/center bill type and provider number. All RHCs and FQHCs must use revenue code 078X when billing for the originating site facility fee. For all other non-RHC/FQHC services, provider based RHCs and FQHCs must bill using the base provider's bill type and billing number. Independent RHCs and FQHCs must bill the carrier for all other non-RHC/FQHC services. If an RHC/FQHC visit occurs on the same day as a telehealth service, the RHC/FQHC serving as an originating site must bill for HCPCS code Q3014 telehealth originating site facility fee on a separate revenue line from the RHC/FQHC visit using revenue code 078X.

Hospital-based or CAH-based renal dialysis centers (including satellites) bill their local FIs and/or Part A MACs for the originating site facility fee. Telehealth bills originating in renal dialysis centers must be submitted on a 72X TOB. All hospital-based or CAH-based renal dialysis centers (including satellites) must use revenue code 078X when billing for the originating site facility fee. The renal dialysis center serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary.

Skilled nursing facilities (SNFs) bill their local FIs and/or Part A MACs for the originating site facility fee. Telehealth bills originating in SNFs must be submitted on TOB 22X or 23X. For SNF inpatients in a covered Part A stay, the originating site facility fee must be submitted on a 22X TOB. All SNFs must use revenue code 078X when billing for the originating site facility fee. The SNF serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary.

Community mental health centers (CMHCs) bill their local FIs and/or Part A MACs for the originating site facility fee. Telehealth bills originating in CMHCs must be submitted on a 76X TOB. All CMHCs must use revenue code 078X when billing for the originating site facility fee. The CMHC serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary. Note that Q3014 does not count towards the number of services used to determine per diem payments for partial hospitalization services.

The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.