CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3476	**Date: March 11, 2016**
	Change Request 9428

SUBJECT: Telehealth Services

I. SUMMARY OF CHANGES: The purpose of this change request is to display the list of telehealth services that were once available through the manual updates to now be displayed via a weblink going forward. CMS is also adding CRNAs to the list of Medicare practitioners who may bill for covered telehealth services. Lastly, the telehealth language has been removed from Pub 100.02, Chapter 15, Section 270 and a reference added in text to see Pub 100.04, Chapter 12, Section 190 for further information regarding telehealth services.

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 11, 2016

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	12/190.3/List of Medicare Telehealth Services
N	12/190.3.4/Payment for ESRD-Related Services as a Telehealth Service
N	12/190.3.5/Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services
N	12/190.3.6/Payment for Diabetes Self-Management Training (DSMT) as a Telehealth Service
R	12/190.5/Originating Site Facility Fee Payment Methodology
R	12/190.6/Payment Methodology for Physician/Practitioner at the Distant Site
R	12/190.6.1/Submission of Telehealth Claims for Distant Site Practitioners

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: 3476	Date: March 11, 2016	Change Request: 9428

SUBJECT: Telehealth Services

EFFECTIVE DATE: January 1, 2015
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IMPLEMENTATION DATE: April 11, 2016

I. GENERAL INFORMATION

A. Background: Several conditions must be met for Medicare to make payments for telehealth services under the Physician Fee Schedule. The service must be on the list of Medicare telehealth services and meet all of the following additional requirements:

- The service must be furnished via an interactive telecommunications system.
- The service must be furnished by a physician or authorized practitioner.
- The service must be furnished to an eligible telehealth individual.
- The individual receiving the service must be located in a telehealth originating site.

B. Policy: The purpose of this change request is to display the list of telehealth services that were once available through the manual updates to now be displayed via a weblink going forward. CMS is also adding CRNAs to the list of Medicare practitioners who may bill for covered telehealth services. Lastly, the telehealth language has been removed from Pub 100.02, Chapter 15, Section 270 and a reference added in text to see Pub 100.04, Chapter 12, Section 190 for further information regarding telehealth services.

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	
9428 - 04.1	Contractors shall be aware that the list of telehealth services shall now be available via the weblink as indicated in Pub 100-04, chapter 12, section 190.	X	X							
9428 - 04.2	Contractors shall be aware that Certified Registered Nurse Anesthetists are added to the list of Medicare practitioners who may bill for covered telehealth	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	services as indicated in Pub 100-04, chapter 12, section 190.6.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9428 - 04.3	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: 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): Jessica Bruton, 410-786-5991 or jessica.bruton@cms.hhs.gov, Kenneth Marsalek, 410-786-4502 or Kenneth.Marsalek@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

Table of Contents
(Rev. 3476, Issued: 03-11-16)

190.3 - List of Medicare Telehealth Services

(Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16)

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 *on the CMS website at www.cms.gov/Medicare/Medicare-General-Information/Telehealth/*

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.

190.3.4 – Payment for ESRD-Related Services as a Telehealth Service

(Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16)

The ESRD-related services included in the monthly capitation payment (MCP) with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month may be paid as Medicare telehealth services. However, at least 1 visit must be furnished face-to-face "hands on" to examine the vascular access site by a physician, clinical nurse specialist, nurse practitioner, or physician assistant. An interactive audio and video telecommunications system may be used for providing additional visits required under the 2-to-3 visit MCP and the 4-or-more visit MCP. The medical record must indicate that at least one of the visits was furnished face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner, or physician assistant.

The MCP physician, for example, the physician or practitioner who is responsible for the complete monthly assessment of the patient and establishes the patient's plan of care, may use other physicians and practitioners to furnish ESRD-related visits through an interactive audio and video telecommunications system. The non-MCP physician or practitioner must have a relationship with the billing physician or practitioner such as a partner, employees of the same group practice or an employee of the MCP physician, for example, the non MCP physician or practitioner is either a W-2 employee or 1099 independent contractor. However, the physician or practitioner who is responsible for the complete monthly assessment and establishes the ESRD beneficiary's plan of care should bill for the MCP in any given month.

Clinical Criteria

The visit, including a clinical examination of the vascular access site, must be conducted face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner or physician's assistant. For additional visits, the physician or practitioner at the distant site is required, at a minimum, to use an interactive audio and video telecommunications system that allows the physician or practitioner to provide medical management services for a maintenance dialysis beneficiary. For example, an ESRD-related visit conducted via telecommunications system must permit the physician or practitioner at the distant site to perform an assessment of whether the dialysis is working effectively and whether the patient is tolerating the procedure well (physiologically and psychologically). During this assessment, the physician or practitioner at the distant site must be able to determine whether alteration in any aspect of the beneficiary's prescription is indicated, due to such changes as the estimate of the patient's dry weight.

190.3.5 – Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services

(Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16)

Subsequent hospital care services are limited to one telehealth visit every 3 days. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes.

Similarly, subsequent nursing facility care services are limited to one telehealth visit every 30 days. Furthermore, subsequent nursing facility care services reported for a Federally-mandated periodic visit under 42 CFR 483.40(c) may not be furnished through telehealth. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes.

Inpatient telehealth consultations are furnished to beneficiaries in hospitals or skilled nursing facilities 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 or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner. 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 and follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in section 190.3 of this chapter.

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

(Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16)

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 the –GT or –GQ modifier 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.

190.5 - *Originating Site Facility Fee Payment Methodology*

(Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16)

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 was 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 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 A/B MAC (B) 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 A/B MAC (B) 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 A/B/MAC (A) 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 A/B/MAC (A) 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 A/B MAC (B) 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 A/B/MAC (A) 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 A/B/MAC (A) 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 A/B/MAC (A) 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.

190.6 - *Payment Methodology for Physician/Practitioner at the Distant Site*

(Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16)

1. Distant Site Defined

The term "distant site" means the site where the physician or practitioner, providing the professional service, is located at the time the service is provided via a telecommunications system.

2. Payment Amount (professional fee)

The payment amount for the professional service provided via a telecommunications system by the physician or practitioner at the distant site is equal to the current fee schedule amount for the service provided. Payment for an office visit, consultation, individual psychotherapy or pharmacologic management via a telecommunications system should be made at the same amount as when these services are furnished without the use of a telecommunications system. For Medicare payment to occur, the service must be within a practitioner's scope of practice under State law. The beneficiary is responsible for any unmet deductible amount and applicable coinsurance.

3. Medicare Practitioners Who May Receive Payment at the Distant Site (i.e., at a site other than where beneficiary is)

As a condition of Medicare Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under state law. When the physician or practitioner at the distant site is licensed under state law to provide a covered telehealth service (i.e., professional consultation, office and other outpatient visits, individual psychotherapy, and pharmacologic management) then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

If the physician or practitioner at 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 A/B/MAC (A) 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.

4. Medicare Practitioners Who May Bill for Covered Telehealth Services are Listed Below (subject to State law)

Physician
Nurse practitioner
Physician assistant
Nurse-midwife
Clinical nurse specialist
*Clinical psychologist**
*Clinical social worker**
Registered dietitian or nutrition professional
Certified registered nurse anesthetist

**Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.*

190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners

(Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16)

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 along with the "GT" modifier ("via interactive audio and video telecommunications system"). By coding and billing the "GT" modifier 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 coding and billing the "GT" modifier 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, *A/B/MACs (A)* should make payment for telehealth services provided by the physician or practitioner at 80 percent of the MPFS amount for the distant site service. In all other cases, except for MNT services as discussed in Section 190.7-Contractor 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, for example, "99245 GT." Physicians' and practitioners' offices serving as a telehealth originating site bill their *A/B/MAC (B)* for the originating site facility fee.