CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1026	**Date: AUGUST 11, 2006**
	Change Request 5201

Subject: Medicare Telehealth Services

I. SUMMARY OF CHANGES: A correction was made to the payment amount regarding telehealth services when the distant site practitioner is located in a critical access hospital. Chapter 12, Section 190.6.1 was revised to reflect these policy changes.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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	12/190.1/Background
R	12/190.6/Originating Site Facility Fee Payment Methodology
R	12/190.6.1/Submission of Telehealth Claims for Distant Site Practitioners

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY **2007** operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1026	Date: August 11, 2006	Change Request 5201

SUBJECT: Medicare Telehealth Services

I. GENERAL INFORMATION

A. Background: CMS provides a correction regarding the payment amount for telehealth services when the distant site practitioner is located in a critical access hospital (CAH) that has elected Method II, and the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, FIs will make payment for the telehealth service at 80 percent of the Medicare physician fee schedule (MPFS) and not according to the optional method as discussed in Pub. 100-04, Chapter 4, Section 250.2.

B. Policy: In situations where a CAH has elected payment Method II for CAH outpatients, and the practitioner has reassigned his/her benefits to the CAH, FIs should make payment for telehealth services provided by the physician or practitioner at 80 percent of the MPFS amount for the distant site service.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5201.1	FISS shall delete revenue code 078x from the list of revenue codes prohibited on TOBs 12x. When this edit fires, the provider receives reason code 34910.					X				
5201.2	Effective January 1, 2007, FISS shall make the necessary changes to allow for payment of telehealth services to a Method II CAH outpatient department at 80 percent of the MPFS fee amount.					X				
5201.3	FISS shall make the necessary changes to only make payment for HCPCS code Q3014 based on the originating site facility fee payment methodology regardless of revenue code or TOB.					X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5201.4	A provider education article related to this instruction will be available at 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 and incorporated into any educational events on this topic. 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								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2007 **Implementation Date:** January 2, 2007 **Pre-Implementation Contact(s):** Policy: Craig Dobyski (410) 786-4584; Craig.Dobyski@cms.hhs.gov **Carrier Claims Processing:** Kathy Kersell (410) 786-2033; Kathleen.Kersell@cms.hhs.gov **Institutional billing questions on telehealth services should be directed to:** Gertrude Saunders, (410) 786-5888; Gertrude.Saunders@cms.hhs.gov or Cindy Murphy, (410) 786-5733; Cindy.Murphy@cms.hhs.gov. **Post-Implementation Contact(s):** Appropriate Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

*__Unless otherwise specified, the effective date is the date of service.__

190.1 - Background

(Rev. 1026, Issued: 08-11-06: Effective: 01-01-07; Implementation: 01-02-07)

Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) - Revision of Medicare Reimbursement for Telehealth Services amended §1834 of the Act to provide for an expansion of Medicare payment for telehealth services.

Effective October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system. Eligible geographic areas include rural health professional shortage areas *(HPSA)* and counties not classified as a metropolitan statistical area (MSA). Additionally, Federal telemedicine demonstration projects as of December 31, 2000, may serve as the originating site regardless of geographic location.

An interactive telecommunications system is required as a condition of payment; however, BIPA does allow the use of asynchronous "store and forward" technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. BIPA does not require that a practitioner present the patient for interactive telehealth services.

With regard to payment amount, BIPA specified that payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at time of telemedicine encounter) is equal to what would have been paid without the use of telemedicine. Distant site practitioners include only a physician as described in §1861(r) of the Act and a medical practitioner as described in §1842(b)(18)(C) of the Act. BIPA also expanded payment under Medicare to include a $20 originating site facility fee (location of beneficiary).

Previously, the Balanced Budget Act of 1997 (BBA) limited the scope of Medicare telehealth coverage to consultation services and the implementing regulation prohibited the use of an asynchronous, 'store and forward' telecommunications system. BBA 1997 also required the professional fee to be shared between the referring and consulting practitioners, and prohibited Medicare payment for facility fees and line charges associated with the telemedicine encounter.

BIPA required that Medicare Part B (Supplementary Medical Insurance) pay for this expansion of telehealth services beginning with services furnished on October 1, 2001.

Time limit for teleconsultation provision.

The teleconsultation provision as authorized by §4206 (a) and (b) of the BBA of 1997 and implemented in 42 CFR 410.78 and 414.65 applies only to teleconsultations provided on or after January 1, 1999, and before October 1, 2001.

190.6 - Originating Site Facility Fee Payment Methodology

(Rev. 1026, Issued: 08-11-06: Effective: 01-01-07; Implementation: 01-02-07)

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 (See B, above, for definition of originating site.)

The originating site facility fee is a Part B payment. The contractor pays it outside of the current fee schedule or other payment methodologies (e.g., FIs make payment in addition to the DRG, or OPPS). For *telehealth* services furnished from October 1, 2001, through December 31, 2002, the originating site fee is the lesser of $20 or the actual charge. For services furnished on or after January 1 of each subsequent year, the Medicare Economic Index (MEI) will update the facility site fee for the originating site annually. This fee is subject to post payment verification.

3. Payment amount:

For telehealth services furnished from October 1, 2001, through December 31, 2002, the payment amount to the originating site is the lesser of the actual charge or the originating site facility fee of $20. 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. Payment is not based on current fee schedules or other payment methodologies.

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 as described above, separately from the cost-based reimbursement methodology.

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 the actual charge or $20 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 physician fee schedule.

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 and it is not priced off of the MPFS Database file. 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, 71X, 73X, and 85X. The originating site can be located in a number of revenue centers within a facility, such as an emergency room (0450), operating room (0360), or clinic (0510). Report this service under the revenue center where the service was performed 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.

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

190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners

(Rev. 1026, Issued: 08-11-06: Effective: 01-01-07; Implementation: 01-02-07)

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. *B*y coding and billing the "GT" modifier with a covered ESRD-related service telehealth code (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318), 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 Pub. 100-02, Chapter 15, Section 270.4.1 *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, FIs 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 190.7-Contractor Editing of Telehealth Claims, telehealth services provided by the physician or practitioner at the distant site are billed to the carrier.

Physicians and practitioners at the distant site bill their local Medicare carrier for covered telehealth services, for example, "99245 GT." Physicians' and practitioners' offices serving as a telehealth originating site bill their local Medicare carrier for the originating site facility fee.