CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 151	**Date: November 18, 2011**
	Change Request 7504

Transmittal 146, dated August 12, 2011, is being rescinded and replaced by Transmittal 151, dated November 18, 2011, to amend Business Requirement 7504-02.3 and the corresponding manual instructions to conform to final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	15/270.2/List of Medicare Telehealth Services
R	15/270.5/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. 100-02	Transmittal: 151	Date: November 18, 2011	Change Request: 7504

Transmittal 146, dated August 12, 2011, is being rescinded and replaced by Transmittal 151, dated November 18, 2011, to amend Business Requirement 7504-02.3 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

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

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	
7504-02.1	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						
7504-02.2	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				
7504-02.3	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	
7504-02.4	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.

270.2 – List of Medicare Telehealth Services

(Rev. 151, Issued: 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. These services are listed below.

Consultations (Effective October 1, 2001- December 31, 2009)

Telehealth consultations, emergency department or initial inpatient (Effective January 1, 2010)

Follow-up inpatient telehealth consultations (Effective January 1, 2009)

Office or other outpatient visits

Subsequent hospital care services (with the limitation of one telehealth visit every 3 days) (Effective January 1, 2011)

Subsequent nursing facility care services (with the limitation of one telehealth visit every 30 days) (Effective January 1, 2011)

Individual psychotherapy

Pharmacologic management

Psychiatric diagnostic interview examination (Effective March 1, 2003)

End stage renal disease related services (Effective January 1, 2005)

Individual and group medical nutrition therapy (Individual effective January 1, 2006; group effective January 1, 2011)

Neurobehavioral status exam (Effective January 1, 2008)

Individual and group health and behavior assessment and intervention (Individual effective January 1, 2010; group effective January 1, 2011)

Individual and group kidney disease education (KDE) services (Effective January 1, 2011)

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) (Effective January 1, 2011)

Smoking Cessation Services (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. For detailed instructions regarding reporting these and other telehealth services, see Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 190.3.

The conditions of payment for Medicare telehealth services, including qualifying originating sites and the types of telecommunications systems recognized by Medicare, are subject to the provisions of 42 CFR 410.78. Payment for these services is subject to the provisions of 42 CFR 414.65.

270.5 - Originating Site Facility Fee Payment Methodology

(Rev.151, Issued: Effective: 01-01-12, Implementation: 01-03-12)

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. 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.*

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:

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.

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.

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

The originating site facility fee for telehealth services is not an FQHC and 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.

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 geographic cost index (GPCI) should not be applied to the originating site facility fee. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the MPFS.

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.

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.

When a CMHC serves as an originating site, 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.