



News Flash – The "Medicare Billing Information for Rural Providers and Suppliers" (ICN 006762)(Sept. 2011) booklet is designed to provide education on Medicare rural billing. It includes information for Rural Health Clinics, Federally Qualified Health Centers, Skilled Nursing Facilities, Home Health Agencies, Critical Access Hospitals, and Swing Beds. To access the downloadable version of the Rural Health Bookmark, visit <http://go.cms.gov/MLNProducts>, scroll down to "Related Links" and select "MLN Product Ordering Page."

MLN Matters® Number: MM6705

Related Change Request (CR) #: 6705

Related CR Release Date: December 18, 2009

Effective Date: January 1, 2010

Related CR Transmittal #: R1881CP and R118BP

Implementation Date: January 4, 2010

Note: This article was updated on January 18, 2013, to reflect current Web addresses. All other information remains unchanged.

Expansion of Medicare Telehealth Services for Calendar Year (CY) 2010

Provider Types Affected

Physicians, hospitals, and skilled nursing facilities (SNFs) submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for telehealth services provided to Medicare beneficiaries are affected by this article.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) added three Healthcare Common Procedure Coding System (HCPCS) codes, 96150-96152, to the list of Medicare distant site telehealth services for individual health and behavior assessment and intervention (HBAI) services. CMS also added three new HCPCS codes, G0425-G0427, for initial inpatient telehealth consultations and expanded coverage of HCPCS codes G0406-G0408, for follow-up inpatient telehealth consultations, to include telehealth services furnished to beneficiaries in a SNF.

These changes are discussed in the calendar year (CY) 2010 physician fee schedule final rule (with comment period (CMS-1413-FC)). This article highlights the related policy instructions. Be sure your billing staff is aware of these changes.

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Background

As noted in the calendar year 2010 physician fee schedule final rule with comment period (CMS-1413-FC; see <http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf>), CMS did the following:

- Added three codes to the list of Medicare distant site telehealth services for **individual health and behavior assessment and intervention (HBAI) services**,
- Added three codes for **initial inpatient telehealth consultations**, and
- Expanded the definition of **follow-up inpatient telehealth consultations** to include consultative visits furnished via telehealth to beneficiaries in SNFs as well as hospitals).

These codes are included in the calendar year (CY) 2010 HCPCS- annual update. Change Request (CR) 6705 adds the relevant policy instructions to the manuals, as finalized in the regulations.

The list of Medicare telehealth services was expanded to include:

- **Individual HBAI**, as described by:
 - **HCPCS Code 96150 (Initial Assessment)**: Practitioners conducting the initial assessment of the patient to determine the biological, psychological, and social factors affecting the patient's physical health and any treatment problems;
 - **HCPCS Code 96151 (Re-Assessment)**: Practitioners conducting a re-assessment of the patient to evaluate the patient's condition and determine the need for further treatment. A re-assessment may be performed by a clinician other than the one who conducted the patient's initial assessment; and
 - **HCPCS Code 96152 (Intervention - Individual)**: Practitioners conducting intervention services provided to an *individual* to modify the psychological, behavioral, cognitive, and social factors affecting the patient's physical health and well being. Examples include increasing the patient's awareness about his or her disease and using cognitive and behavioral approaches to initiate physician prescribed diet and exercise regimens; and
- **Initial inpatient telehealth consultations** provided at various levels of complexity as described by:
 - **HCPCS G0425 (Problem Focused)**: Practitioners taking a problem focused history, conducting a problem focused examination, and

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engaging in medical decision making that is straightforward. At this level of service, practitioners would typically spend 30 minutes communicating with the patient via telehealth;

- **HCPCS G0426** (Detailed): Practitioners taking a detailed history, conducting a detailed examination, and engaging in medical decision making that is of moderate complexity. At this level of service, practitioners would typically spend 50 minutes communicating with the patient via telehealth; and
- **HCPCS G0427** (Comprehensive): Practitioners taking a comprehensive history, conducting a comprehensive examination, and engaging in medical decision making that is of high complexity. At this level of service, practitioners would typically spend 70 minutes or more communicating with the patient via telehealth.

In addition, effective January 1, 2010, the following is valid when billed for telehealth services furnished to beneficiaries in hospitals or SNFs:

- Follow-up inpatient telehealth consultations, as described by:
 - **HCPCS G0406**: Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth;
 - **HCPCS G0407**: Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth; and
 - **HCPCS G0408**: Follow-up inpatient telehealth consultation, complex, physicians typically spend 35 minutes or more communicating with the patient via telehealth.

Note that Codes G0406-G0408 have been effective since January 1, 2009, but were only valid for telehealth services provided to a beneficiary in an inpatient hospital. As of January 1, 2010, these three codes are also billable for telehealth services furnished to beneficiaries in a SNF.

The following telehealth modifiers are required when billing for telehealth services with codes 96150-96152 and G0425-G0427:

- "GT" (via interactive audio and video telecommunications system); and
- "GQ" (via asynchronous telecommunications system).

Note: Consistent with existing telehealth policy, all telehealth services must be billed with either the "GT" or "GQ" modifier to identify the telehealth technology used to provide the service.

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Effective January 1, 2010, CMS eliminated the use of all AMA Current Procedural Terminology (CPT) consultation codes. (See the MLN Matters® article at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6740.pdf> for full details.) Because revisions in consultation services payment policy affect telehealth policy, CR 6705 includes references to the revisions relevant to professional consultations furnished via telehealth.

Effective January 1, 2010:

- CMS will no longer recognize office/outpatient consultation CPT codes 99241-99245.
 - Instead, physicians and practitioners are instructed to bill a new or established patient visit CPT code in the range of CPT codes 99201-99215, as appropriate to the particular patient, for all office/outpatient visits furnished via telehealth; and
- CMS will no longer recognize initial inpatient consultation CPT codes 99251-99255.
 - Instead, CMS created HCPCS codes G0425-G0427 specific to the telehealth delivery of initial inpatient consultations to retain the ability for practitioners to furnish and bill for initial inpatient consultations delivered via telehealth.

This expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, payment or billing methodology applicable to Medicare telehealth services as set forth in the *Medicare Benefit Policy Manual* (Chapter 15, section 270) and the *Medicare Claims Processing Manual* (Chapter 12, section 190). These manuals are available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html> on the CMS website.

Additional Information

The official instruction, CR 6705, was issued in two transmittals to your carrier, FI, and A/B MAC. The first transmittal revises the Medicare Benefit Policy Manual and is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R118BP.pdf> and the second transmittal, which modifies the Medicare Claims Processing Manual, is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1881CP.pdf> on the CMS website.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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