Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – ICD-10 Medicare Severity Diagnosis Related Grouper (MS-DRG), Version 30.0 (FY 2013) mainframe and PC software is now available. This software is being provided to offer the public a better opportunity to review and comment on the ICD-10 MS-DRG conversion of the MS-DRGs. This software can be ordered through the National Technical Information Service (NTIS) website. A link to NTIS is also available in the Related Links section of the ICD-10 MS-DRG Conversion Project website. The final version of the ICD-10 MS-DRGs will be subject to formal rulemaking and will be implemented on October 1, 2014.

MLN Matters® Number: MM7049

Related Change Request (CR) #: 7049

Related CR Release Date: February 28, 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R2168CP and R140BP

Implementation Date: January 3, 2011 (for those billing Carriers or A/B MACs); April 4, 2011 (for those billing Fiscal Intermediaries or A/B MACs)

Expansion of Medicare Telehealth Services for Calendar Year (CY) 2011

Note: This article was revised on March 22, 2013, with an updated ICD-10 News Flash. This article was previously updated on December 7, 2012, to reflect current Web addresses. This article was revised on April 19, 2012, to add a reference to SE1209 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1209.pdf) to alert providers how new Medicare provider inquiry screens provide the date on which a beneficiary is next eligible for certain frequency-limited telehealth services. All other information remains unchanged.

Provider Types Affected

This MLN Matters® Article for Change Request (CR) 7049 is intended for physicians, Non-Physician Practitioners (NPPs), 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.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7049 to alert providers that 14 Healthcare Common Procedure Coding System (HCPCS) codes were added to the list of Medicare telehealth services for:

- Individual and group Kidney Disease Education (KDE) services;
- Individual and group Diabetes Self-Management Training (DSMT) services;
- Group Medical Nutrition Therapy (MNT) services;
- Group Health and Behavior Assessment and Intervention (HBAI) services; and
- Subsequent hospital care and nursing facility care services.

Make sure your billing staffs are aware of these changes.

Background

As noted in the 2011 "Medicare Physician Fee Schedule Final Rule" published on November 29, 2010, CMS is adding14 codes to the list of Medicare distant site telehealth services for individual and group KDE services, individual and group DSMT services, group MNT services, group HBAI services, and subsequent hospital care and nursing facility care services. Payment for these services will be made at the applicable Physician Fee Schedule (PFS) payment amount for the service of the physician or practitioner. CR7049 adds the relevant policy instructions to the "Medicare Claims Processing Manual" and the "Medicare Benefit Policy Manual" and those changes may be reviewed by consulting CR7049 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2168CP.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R140BP.pdf on the CMS website.

Key Points of CR7049

CMS is adding the following requested services to the list of Medicare telehealth services for CY 2011:

- Individual and group KDE services:
  - HCPCS code G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour); and
  - HCPCS code G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour).
- Individual and group 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 code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes); and
  - HCPCS code G0109 (Diabetes outpatient self-management training services, group session (2 or more) per 30 minutes).
- Group MNT and HBAI services, Current Procedural Terminology (CPT) codes: 97804 (Medical

nutrition therapy; group (2 or more individual(s)), each 30 minutes), 96153 (Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients), and 96154 (Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present));

- Subsequent hospital care services, with the limitation of one telehealth visit every 3 days; CPT codes:
  - 99231 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit),
  - 99232 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication), and
  - 99233(Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit); and
- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days, CPT codes:
  - 99307 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit),
  - 99308 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision

making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit),

- 99309 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit), and
- 99310 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

Note: The frequency limitations on subsequent hospital care and subsequent nursing facility care delivered through telehealth do not apply to inpatient telehealth consultations. Consulting practitioners should continue to use the inpatient telehealth consultation HCPCS codes (G0406, G0407, G0408, G0425, G0426, or G0427) when reporting consultations furnished via telehealth.

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.

- For Dates of Service (DOS) on or after January 1, 2011, Medicare contractors will accept and pay the added codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ or GT modifier.
- For dates of service on or after January 1, 2011, Medicare contractors will accept and pay the added codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ or GT modifier by Critical Access Hospitals (CAHs) that have elected Method II on TOB 85X.

Additional Information

Your Medicare contractor will not search their files to reprocess any impacted claims that were processed prior to the implementation dates above. However, they will adjust such claims that you bring to their attention.

If you have questions, please contact your Medicare A/B MAC, carrier and/or FI 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. CR7049 adds the relevant policy instructions to the "Medicare Claims Processing Manual" and the "Medicare Benefit Policy Manual" and those changes may be reviewed by consulting CR7049 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2168CP.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R140BP.pdf on the CMS website.