

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2095	Date: June 20, 2018
	Change Request 10583

Transmittal 4026, dated April 27, 2018, is being rescinded and replaced by Transmittal 2095, dated, June 20, 2018 to revise business requirement 10583.1. All other information remains the same.

SUBJECT: Revisions to the Telehealth Billing Requirements for Distant Site Services

I. SUMMARY OF CHANGES: This change request implements requirement for billing modifier GT for Telehealth Distant Site Services.

EFFECTIVE DATE: October 1, 2018

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

IMPLEMENTATION DATE: October 1, 2018

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-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

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SUBJECT: Revisions to the Telehealth Billing Requirements for Distant Site Services

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I. GENERAL INFORMATION

A. Background: Previous guidance instructed providers to submit claims for telehealth services using the appropriate procedure code along with the telehealth modifier GT (via interactive audio and video telecommunications systems). In the Calendar Year (CY) 2017 Physician Fee Schedule (PFS) final rule, payment policies regarding Medicare’s use of a new Place of Service (POS) code describing services furnished via telehealth (POS 02) were finalized and implemented through CR 9726. The new POS code became effective January 1, 2017. In the CY 2018 PFS final rule, the requirement to use the GT modifier was eliminated for all professional claims. CR 10152, which implemented that policy, included a business requirement instructing contractors to be aware that the GT modifier would still be required for distant site services billed under Critical Access Hospital (CAH) Method II on institutional claims.

B. Policy: As of October 1, 2018, the GT modifier is only allowed on institutional claims billed under CAH Method II.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC		D M E	Shared- System Maintainers				Other		
		A	B		H H H	M A C	F I S S	M C S		V M S	C W F
10583.1	Contractors shall create a line level reason code to reject any service line(s) that contains a modifier 'GT', except when: <ul style="list-style-type: none"> • the type of bill is a CAH method II with revenue code 96X, 97X, or 98X; or • the service line contains Healthcare Common Procedure Coding System (HCPCS) code Q3014; or • the type of bill is a CAH method II with revenue code 942 and G0420 or G0421. 					X					

Number	Requirement	Responsibility							
		A/B MAC		H H H	D M E M A C	Shared- System Maintainers			Other
		A	B			F I S S	M C S	V M S	
10583.2	<p>Contractors shall reject the line with the following:</p> <p>Group Code CO - Contractual obligation</p> <p>CARC 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 Last Modified: 07/01/2017</p> <p>RARC N519 - Invalid combination of HCPCS modifiers.</p> <p>MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.</p>	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility					
		A/B MAC		H H H	D M E M A C	C E D I	I
		A	B				
10583.3	<p>MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.</p>	X		X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Lindsey Baldwin, 410-786-1694 or Lindsey.Baldwin@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

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ATTACHMENTS: 0