CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1277	**Date: JUNE 29, 2007**
	Change Request 5628

NOTE: The CY 2008 physician fee schedule rule was published in the Federal Register on November 27, 2007. Change Request (CR) 5628 is no longer sensitive. This manual instruction can be released and posted to the internet. The Transmittal Number, the date released and all other information will remain the same.

Subject: Medicare Telehealth Services

I. SUMMARY OF CHANGES: In the calendar year 2008 physician fee schedule, final rule (CMS-1385-FC), CMS added neurobehavioral status exam as represented by HCPCS code 96116 to the list of Medicare telehealth services. Chapter 12, section 190.3 is being modified to reflect this policy change.

NOTE: The addition of neurobehavioral status exam (as described by HCPCS code 96116) to the list of Medicare telehealth services is dependent upon publication of the physician fee schedule final rule and may be subject to change based on the rulemaking process.

New / Revised Material
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

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	12/190.3/List of Medicare Telehealth Services

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 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: 1277	Date: June 29, 2007	Change Request: 5628

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SUBJECT: Medicare Telehealth Services

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

I. GENERAL INFORMATION

A. Background: In the calendar year 2008 physician fee schedule, final rule (CMS-1385-FC) CMS added neurobehavioral status exam as represented by HCPCS code 96116 to the list of Medicare telehealth services. Regulation text at 42 CFR §§410.78 and 414.65 were modified to add neurobehavioral status exam to the list of telehealth services.

B. Policy: The list of Medicare telehealth services was expanded to include neurobehavioral status exam as described by HCPCS code 96116. Effective January 1, 2008, the telehealth modifier "GT" (via interactive audio and video telecommunications system) and modifier "GQ" (via asynchronous telecommunications system) are valid when billed with this HCPCS code.

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 Pub 100-02, chapter 15, section 270 and Pub 100-04, chapter 12, section 190. For example, originating sites only include a physician's or practitioner's office, hospital, critical access hospital, rural health clinic, Federally qualified health center. Originating sites must be located in either a non-MSA county or rural HPSA. An interactive audio and video telecommunications system must be used permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit. The only exception to the interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In this circumstance, Medicare payment is permitted for telehealth services when asynchronous store and forward technology is used. For more information on Medicare telehealth payment policy and claims processing instructions see Pub100-02, chapter 15, section 270 and Pub 100-04, chapter 12, section 190.

NOTE: The addition of neurobehavioral status exam (as described by HCPCS code 96116) to the list of Medicare telehealth services is dependent upon publication of the physician fee schedule <u>final rule</u> and may be subject to change based on the rulemaking process.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5628.1	Effective January 1, 2008, local Part B carriers and or A/B MACs shall pay for HCPCS code 96116 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier.	X			X							
5628.2	Effective January 1, 2008, local FIs and or A/B MACs shall pay for HCPCS codes 96116 when submitted with a GT or GQ modifier, by CAHs that have elected Method II on TOB 85x.	X		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5628.3	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

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

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

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Policy: Craig Dobyski; Craig.Dobyski@cms.hhs.gov; 410-786-4584.
Carrier claims processing: Bill Stojak;William.Stojak@cms.hhs.gov;410-786-6984.
Intermediary claims processing: Cindy Murphy; Cindy.Murphy@cms.hhs.gov; 410-786-5733
or Gertrude Saunders; Gertrude.Saunders@cms.hhs.gov; 410-786-5888.

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC),* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

B. *For Medicare Administrative Contractors (MAC),* use the following statement:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

190.3 - List of Medicare Telehealth Services

(Rev. 1277, Issued: 06-29-07, Effective: 01-01-08, Implementation: 01-07-08)

The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, end stage renal disease related services, and individual medical nutrition therapy. These services and corresponding current procedure terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes are listed below.

- Consultations (CPT codes 99241 - 99275) - Effective October 1, 2001 – December 31, 2005;
- Consultations (CPT codes 99241 - 99255) - Effective January 1, 2006;
- Office or other outpatient visits (CPT codes 99201 - 99215);
- Individual psychotherapy (CPT codes 90804 - 90809);
- Pharmacologic management (CPT code 90862); and
- Psychiatric diagnostic interview examination (CPT code 90801) – Effective March 1, 2003.
- End Stage Renal Disease (ESRD) related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) – Effective January 1, 2005.
- Individual Medical Nutrition Therapy (HCPCS codes G0270, 97802, and 97803) (Effective January 1, 2006).
- *Neurobehavioral status exam (CPT code 96116) (Effective January 1, 2008).*