CMS Manual System

Pub 100-02 Medicare Benefit Policy

Transmittal 31

Department of Health & Human Services
Center for Medicare and & Medicaid Services
Date: APRIL 1, 2005
Change Request 3747

SUBJECT: List of Medicare Telehealth Services

I. SUMMARY OF CHANGES: In the calendar year 2005 physician fee schedule-final rule, the list of Medicare telehealth services was expanded to include ESRD-related services as described by HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318. Chapter 15, section 270.2 has been revised and new sections 270.4.1 and 270.5.1 have been added to implement this addition to the list of Medicare telehealth services. Section 270 was revised as a background section and is for historical background purposes only.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : **January 01, 2005**
IMPLEMENTATION DATE : **May 2, 2005**

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/Table of Contents
R	15/270/Telehealth Services
R	15/270.2/List of Medicare Telehealth Services
N	15/270.4.1/Payment for ESRD-Related Services as a Telehealth Service
N	15/270.5.1/Originating Site Facility Fee Payment (ESRD-Related Services)

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be

carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-02	Transmittal: 31	Date: April 1, 2005	Change Request 3747

SUBJECT: List of Medicare Telehealth Services

I. GENERAL INFORMATION

A. Background: In the final physician fee schedule rule published November 7, 2003 (68 FR 63216), CMS established new G codes for managing patients on dialysis with payments varying based on the number of visits provided within each month. Under this methodology, separate codes are billed for providing 1 visit per month, 2-3 visits per month, and 4 or more visits per month. The lowest payment amount applies when a physician provides 1 visit per month; a higher payment is provided for 2 to 3 visits per month. To receive the highest payment amount, a physician would have to provide at least 4 ESRD-related visits per month. The G codes require a complete monthly assessment of the beneficiary, including the establishment of a monthly care plan and are reported once per month for services performed in an outpatient setting that are related to the patients' ESRD.

As part of CMS' process for adding services to the list of Medicare telehealth services, the nephrology community expressed concerns that CMS' change in payments for managing patients on dialysis results in hardships for rural and isolated areas, especially in frontier areas where physicians would be forced to make multiple long-distance trips during a month to see their patients or vice versa. To address this issue, CMS added ESRD-related services included in the monthly capitation payment (MCP) to the list of Medicare telehealth services in the physician fee schedule final rule published November 15, 2004 (69 FR 66276).

However, CMS specified that 1 visit per month must be furnished face-to- face "hands on" to examine the vascular access site. Moreover, CMS clarified that only the facilities, as authorized by section 1834(m) of the Act may serve as a Medicare telehealth-originating site. Prior to this change request, the list of Medicare telehealth services included office and other outpatient visits, consultation, individual psychotherapy, pharmacologic management and the psychiatric diagnostic interview examination (as described by CPT codes 99201-99215, 99241-99275, 90804-90809, 90862, and 90801).

B. Policy: The list of Medicare telehealth services has been expanded to include ESRD-related services as described by HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318. Effective January 1, 2005, the telehealth modifiers "GT" (via interactive audio and video telecommunications system) and modifier "GQ" (via asynchronous telecommunications system) are valid when billed with these ESRD-related service HCPCS codes. 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, or Federally qualified health center. Originating sites must be located in either a non-MSA county or rural health professional shortage area. 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 Pub. 100-02, chapter 15, section 270 and Pub. 100-04, chapter 12, section 190.

In order to bill for ESRD-related services under the MCP as a telehealth service, at least 1 visit per month must be furnished face-to-face (not as telehealth) to examine the vascular access site. The clinical examination of the vascular access site must be furnished face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner, or physicians assistant. Additional visits under the MCP may be furnished via an interactive telecommunications system.

By using the telehealth services modifier e.g., G0318 GT, the MCP physician or practitioner attests that a clinical examination of the vascular access site was furnished face-to-face "hands on" by a physician clinical nurse specialist, nurse practitioner, or physician's assistant. The medical record should include sufficient documentation that the complete assessment of the ESRD beneficiary including a clinical examination of the vascular access site was furnished face-to-face.

The Medicare beneficiary must be located in an originating site at the time the telehealth service is furnished. Medicare telehealth originating sites only include a physician's or practitioner's office, hospital, critical access hospital, rural health clinic, or Federally qualified health center. ESRD facilities are not originating sites (dialysis facilities are not defined in the law as an originate site). ESRD-related visits may be furnished through an interactive telecommunications system (other than the required visit to examine the vascular access site) when the beneficiary is located in an originating site as defined in Pub. 100-02, chapter 15, section 270.1 (including a physician's satellite office within a dialysis center).

Clarification for originating sites billing for the telehealth originating site facility fee.

With regard to ESRD-related services included in the MCP, the originating site facility fee payment may be made for each visit furnished through an interactive telecommunications system. When the physician or practitioner at the distant site furnishes an ESRD-related patient visit included in the MCP through an interactive telecommunications system, the originating site may bill for a telehealth facility fee.

Example: A 70 year old ESRD beneficiary receives 2 ESRD-related visits through an interactive telecommunications system and the required face-to-face visit (to examine the vascular access site) during the month of November. In this scenario the originating site should bill for two originating site facility fees as described by HCPCS code Q3014 and the MCP physician at the distant site should bill for ESRD-related services with 2 to 3 visits as a telehealth service, e.g., G3018 GT.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3747.1	Effective January 1, 2005, local part B Carriers shall pay for HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier.			X						
3747.2	Contractors do not have to search their files and reprocess claims for HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 with dates of service on or after January 1, 2005. However, contractors shall adjust any claims for these services that are brought to their attention.			X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3747.3	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	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 and incorporated into your outreach activities, as appropriate. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2005 **Implementation Date:** May 2, 2005 **Pre-Implementation Contact(s):** Policy: Craig Dobyski (410) 786-4584; Cdobyski@cms.hhs.gov Part B Claims Processing: Kathy Kersell (410) 786-2033; KKersell@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

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

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

Table of Contents

(Rev. 31, 04-01-05)

270.4.1- Payment for ESRD-Related Services as a Telehealth Service

270.5.1 - Originating Site Facility Fee Payment (ESRD-Related Services)

270 - Telehealth Services

(Rev. 31, Issued: 04-01-05; Effective: 01-01-05; Implementation: 05-02-05)

Background

Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) - Revision of Medicare Reimbursement for Telehealth Services amended §1834 of the Act to provide for an expansion of Medicare payment for telehealth services.

Effective October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system. Eligible geographic areas include rural health professional shortage areas and counties not classified as a metropolitan statistical area (MSA). Additionally, Federal telemedicine demonstration projects as of December 31, 2000, may serve as the originating site regardless of geographic location.

An interactive telecommunications system is required as a condition of payment; however, BIPA does allow the use of asynchronous "store and forward" technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. BIPA does not require that a practitioner present the patient for interactive telehealth services.

With regard to payment amount, BIPA specified that payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at time of telemedicine encounter) is equal to what would have been paid without the use of telemedicine. Distant site practitioners include only a physician as described in §1861(r) of the Act and a medical practitioner as described in §1842(b)(18)(C) of the Act. BIPA also expanded payment under Medicare to include a $20 originating site facility fee (location of beneficiary).

Previously, the Balanced Budget Act of 1997 (BBA) limited the scope of Medicare telehealth coverage to consultation services and the implementing regulation prohibited the use of an asynchronous 'store and forward' telecommunications system. The BBA of 1997 also required the professional fee to be shared between the referring and consulting practitioners, and prohibited Medicare payment for facility fees and line charges associated with the telemedicine encounter.

BIPA required that Medicare Part B (Supplementary Medical Insurance) pay for this expansion of telehealth services beginning with services furnished on October 1, 2001.

Time limit for teleconsultation provision.

The teleconsultation provision as authorized by §4206 (a) and (b) of the BBA of 1997 and implemented in 42 CFR 410.78 and 414.65 applies only to teleconsultations provided on or after January 1, 1999, and before October 1, 2001.

270.2 – List of Medicare Telehealth Services

(Rev. 31, Issued: 04-01-05; Effective: 01-01-05; Implementation: 05-02-05)

Furnished by CMS

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

- Consultations (CPT codes 99241 - 99275).
- Office or other outpatient visits (CPT codes 99201 - 99215).
- Individual psychotherapy (CPT codes 90804 - 90809).
- Pharmacologic management (CPT code 90862).
- Psychiatric diagnostic interview examination (CPT code 90801) (Effective March1, 2003).
- *End stage renal disease related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318). (Effective January 1, 2005).*

270.4.1 – Payment for ESRD-Related Services as a Telehealth Service

(Rev. 31, Issued: 04-01-05; Effective: 01-01-05; Implementation: 05-02-05)

ESRD-related services included in the monthly capitation payment (MCP) with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month may be paid as Medicare telehealth services. However, at least 1 visit must be furnished face-to-face "hands on" to examine the vascular access site by a physician, clinical nurse specialist, nurse practitioner, or physicians assistant. An interactive audio and video telecommunications system may be used for providing additional visits required under the 2-to-3 visit MCP and the 4-or-more visit MCP. The medical record must indicate that at least one of the visits was furnished face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner, or physician assistant.

The MCP physician, for example, the physician or practitioner who is responsible for the complete monthly assessment of the patient and establishes the patient's plan of care, may use other physicians and practitioners to furnish ESRD-related visits through an interactive audio and video telecommunications system. The non-MCP physician or practitioner must have a relationship with the billing physician or practitioner such as a partner, employees of the same group practice or an employee of the MCP physician, for example, the non MCP physician or practitioner is either a W-2 employee or 1099 independent contractor. However, the physician or practitioner who is responsible for the complete monthly assessment and establishes the ESRD beneficiary's plan of care should bill for the MCP in any given month.

Clinical Criteria

The visit including a clinical examination of the vascular access site must be conducted face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner or physician's assistant. For additional visits, the physician or practitioner at the distant site is required, at a minimum, to use an interactive audio and video telecommunications system that allows the physician or practitioner to provide medical management services for a maintenance dialysis beneficiary. For example, an ESRD-related visit conducted via telecommunications system must permit the physician or practitioner at the distant site to perform an assessment of whether the dialysis is working effectively and whether the patient is tolerating the procedure well (physiologically and psychologically). During this assessment, the physician or practitioner at the distant site must be able to determine whether alteration in any aspect of the beneficiary's prescription is indicated, due to such changes as the estimate of the patient's dry weight.

Clarification on originating sites

Medicare telehealth originating sites only include a physician's or practitioner's office, hospital, critical access hospital, rural health clinic, or Federally-qualified health center. ESRD facilities are not originating sites (dialysis facilities are not defined in the law as an originate site). ESRD-related visits may be furnished through an interactive telecommunications system (other than the required visit to examine the vascular access site) when the beneficiary is located in an originating site as defined in §270.1, including a physician's satellite office within a dialysis center.

270.5.1 Originating Site Facility Fee Payment (ESRD-Related Services)

(Rev. 31, Issued: 04-01-05; Effective: 01-01-05; Implementation: 05-02-05)

With regard to ESRD-related services included in the MCP, the originating site facility fee payment may be made for each visit furnished through an interactive telecommunications system. When the physician or practitioner at the distant site furnishes an ESRD-related patient visit(s) included in the MCP through an interactive telecommunications system, the originating site facility may bill for a telehealth facility fee.

Example: A 70 year old ESRD beneficiary receives 2 ESRD-related visits through an interactive telecommunications system and the required face-to-face visit (to examine the vascular access site) during the month of November. In this scenario the originating site should bill for two originating site facility fees as described by HCPCS code Q3014 and the MCP physician at the distant site should bill for ESRD-related services with 2 to 3 visits as a telehealth service, e.g., G3018 "GT".

For more information on telehealth claims processing see Pub 100-04, Chapter 12, Section 190 (Medicare telehealth claims processing).