CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1776	**Date: July 24, 2009**
	Change Request 6493

Subject: Telehealth Services in Indian Health Service (IHS) or Tribal Providers

I. SUMMARY OF CHANGES: This CR expands instructions for telehealth to add Indian Health Service (IHS)/Tribal Providers for both the originating site facility fee and payment to the distant site physician or practitioner. Also included in this CR are the requisite shared systems changes to permit appropriate payment for both the telehealth originating site facility fee and for the services of distant site physicians and practitioners.

NEW / REVISED MATERIAL
EFFECTIVE DATE: January 1, 2009
IMPLEMENTATION DATE: January 4, 2010

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:
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	**Chapter/Section.Subsection/Title**
R	19/Table of Contents
R	19/20.2/Overview of Medicare Part B Services
R	19/100.1/FI - Medicare Part B Services Paid Under Various Fee Schedules
R	19/100.3.4.1/FI - Inpatient Ancillary Services - Medicare Part B - Claims Processing
R	19/100.5.1/FI - Outpatient - Medicare Part B - Claims Processing
R	19/100.7.2.1/FI - CAH Ancillary Services - Medicare Part B - Claims Processing
R	19/100.9.1/FI - CAH Outpatient - Medicare Part B - Claims Processing
N	19/100.16/FI - Payment for Telehealth Services to Indian Health Service/Tribal Facilities and Practitioners
N	19/100.16.1/FI - Telehealth Originating Site Facility Fee - Medicare Part B - Payment Policy
N	19/100.16.2/FI - Telehealth Originating Site Facility Fee - Medicare Part B - Claims Processing
N	19/100.16.3/FI - Payment for Distant Site Practitioner Services

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1776	Date: July 24, 2009	Change Request: 6493

SUBJECT: Telehealth Services in Indian Health Service (IHS) or Tribal Providers

Effective Date: January 1, 2009

Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A. 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. 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.

Distant site practitioners include only physicians and selected medical practitioners, specifically, any of the following practitioners: physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse-midwife, clinical social worker (CSW), clinical psychologist (CP), or registered dietician or nutrition professional. Payment for distant site practitioners is equal to what would have been paid without the use of telemedicine. BIPA also expanded payment under Medicare to include a $20 originating site facility fee (location of beneficiary).

Aside from the Federal telemedicine demonstration in Alaska and Hawaii, eligibility of originating sites is limited to rural health professional shortage areas (HPSAs) and counties not classified as a metropolitan statistical area (MSA).

B. Policy:

Because payment for the originating site is specified in legislation, systems changes are required in the shared system to make payment on this basis to IHS/tribal facilities, rather than based on the all-inclusive rate (AIR). The originating site facility fee is equal to $23.72 for the period January 1, 2009 through December 31, 2009. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI). For CY 2009, the payment amount is 80 percent of the lesser of the actual charge or $23.72. The usual Part B coinsurance and deductible apply, but are waived for IHS/Tribal facilities. Distant site practitioners, including physicians, are paid using the Medicare physician fee schedule (MPFS).

The originating sites for Medicare telehealth services include the office of a physician or practitioner; a hospital; a critical access hospital (CAH); a rural health clinic; and a federally qualified health center. For IHS/Tribal institutions, the originating site facility fees may be paid on the following types of bills (TOBs): 12x, 13x, 71x, 73x, 77x, or 85x.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6493.1	Contractors shall accept claims for the telehealth originating site facility fee from rural IHS/Tribal facilities when submitted on the following TOBs: 12x, 13x, 71x, 73x, 77x, or 85x.	X		X			X				
6493.2	Contractors shall accept claims for the telehealth originating site facility fee from rural IHS/Tribal practitioners, including physicians.	X			X						
6493.3	Contractors shall make payment for eligible telehealth originating site facility fee claims when HCPCS code Q3014 is present.	X		X	X		X				
6493.3.1	All institutional claims for the originating site facility fee (Q3014) shall use revenue code 0780.	X		X			X				
6493.4	Contractors shall accept claims for distant site telehealth services from any of the following IHS/Tribal medical practitioners: physicians, PAs, NPs, CNSs, certified nurse-midwives, CSWs, CPs, registered dieticians, and nutrition professionals.	X			X						
6493.4.1	Contractors shall accept the following HCPCS codes for distant site telehealth services: 99241 – 99255, 99201 – 99215, 90804 – 90809, 90862, 90801, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961 G0270, 97802, 97803, 96116, and G0406 -- G0408.	X		X	X						
6493.4.2	Contractors shall accept claims from physicians and practitioners that have appended either the modifier GT or GQ to the distant site HCPCS listed in BR 6493.4.1.	X		X	X						

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6493.4.3	Contractors shall accept claims for distant site telehealth services from IHS/Tribal Method II CAHs for the services of any of the following medical practitioners: physicians, PAs, NPs, CNSs, certified nurse-midwives, CSWs, CPs, registered dieticians, and nutrition professionals.	X		X			X				
6493.5	Contractors shall make payment for the originating site facility fee at 80% of the lesser of the actual charge or $23.72 for CY 2009.	X		X	X		X				
6493.6	Contractors shall make payment for distant site telehealth services in the same amount as if the services were face-to-face. NOTE: Payment shall be based on 80% of the Medicare Physician Fee Schedule payment amount for a physician, and the appropriate step down percentages for other practitioners.	X		X	X		X				
6493.7	When making payment to IHS/Tribal facilities, physicians, and practitioners, the J4 MAC shall apply any applicable deductible and coinsurance, which is waived by IHS.	X					X				
6493.7.1	The J4 MAC shall suppress the MSN when payment is to IHS/Tribal facilities, physicians, and practitioners.	X					X				
6493.8	Contractors do not have to search their files and reprocess claims for IHS/Tribal facility and practitioner telehealth services with dates of service on or after 1/1/2009, but shall adjust claims for these services that are brought to their attention.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6493.9	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 one 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

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

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

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

V. CONTACTS

Pre-Implementation Contact(s): Cindy Murphy (410) 786-5733, cindy.murphy@cms.hhs.gov or Gertrude Saunders (410) 786-5888, gertrude.saunders@cms.hhs.gov

Post-Implementation Contact(s): Dallas Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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

Section B: *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.

Medicare Claims Processing Manual

Chapter 19 – Indian Health Services

Table of Contents
(Rev.1776, 07-24-09)

20.2 - Overview of Medicare Part B Services

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

Section 630 of the MMA extended to IHS providers, suppliers, physicians and practitioners, independent ambulance suppliers, hospital based ambulance providers and clinical laboratory service suppliers the ability to bill for all Medicare Part B covered services and items which were not covered under BIPA (for a 5 year period). This includes all screening and preventive services covered by Medicare. This chapter contains the effective dates for services implemented under §630 of the MMA.

For the 5 year period beginning January 1, 2005, IHS providers and suppliers may bill Medicare for the following Medicare Part B services:

- DME;
- Prosthetics and orthotics;
- Prosthetic devices;
- Surgical dressings, splints and casts;
- Therapeutic shoes;
- Drugs (DME MAC drugs);
- Clinical laboratory services;
- Ambulance services; and
- Screening and preventive services not already covered.

Payment is made on the AIR for IHS providers. *Payment is made* on the appropriate fee schedule for IHS suppliers:

- The Medicare Physician Fee Schedule (MPFS);
- The Clinical Diagnostic Laboratory Fee Schedule;
- The Ambulance Fee Schedule;
- The DMEPOS Fee Schedule;
- The Anesthesia Fee Schedule; or
- DME MAC Drugs – based on the average sales price (ASP).

The nature of the provider or supplier, the location where the service is furnished and the service being rendered determines if the carrier, FI, *Part A/B MAC,* or regional DME MAC shall be billed. Most services that are paid under a fee schedule are billed to either the designated carrier or the (regional) DME MAC. Some fee schedule paid services are billed to the designated FI. For example, physical therapy may be billed to the designated carrier *or Part A/B MAC* by an independent practitioner, but is billed to the FI *or Part A/B MAC* when provided by a hospital outpatient department or by a hospital-based facility.

Refer to §80.3 of this chapter for more information on the claims processing jurisdiction for claims filed by IHS independent ambulance suppliers.

Refer to §80.7.1 of this chapter for more information on the claims processing jurisdiction for claims filed by freestanding facilities for clinical laboratory services.

Refer to §90.2.1 of this chapter for more information on the services billed to DME MAC.

Refer to §90.2.1.1 of this chapter for more information on the services billed to the FI.

Refer to Chapter 1, §10.1.9 of Pub. 100-04, Medicare Claims Processing Manual, for information on misdirected claims.

100.1 - FI - Medicare Part B Services Paid Under Various Fee Schedules

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

The legislative change in MMA §630 of 2003, which was effective January 1, 2005, allows IHS providers to bill for other Medicare Part B services, not covered under §1848 of the Act. In an effort to clarify that these charges are not included in the AIR (which is the general method of payment) and to allow these facilities to acquire the appropriate certifications, IHS providers, including CAHs were allowed to begin billing separately for a period of 5 years, the following Medicare Part B services:

- Prosthetic and orthotic devices (beginning July 1, 2005);
- Surgical dressings (beginning July 1, 2005);
- Influenza, pneumococcal, and hepatitis B vaccines (beginning January 1, 2006); and
- Ambulance services (beginning January 1, 2005.

The enactment of BIPA allowed for separate billing of certain services by physicians and practitioners, including physical therapy, occupational therapy, and speech-language pathology (including diagnostic audiology services).

100.3.4.1 - FI - Inpatient Ancillary Services - Medicare Part B - Claims Processing

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

All charges, except therapies, *telehealth originating site facility fee,* PPV, influenza virus and hepatitis B vaccines are combined and reported under revenue code 024X (all-inclusive ancillary) on TOB 12X (hospital inpatient Part B). Medicare Part B deductible and coinsurance amounts are applied to inpatient Medicare Part B ancillary services, but are waived by the IHS. The MSN is suppressed.

100.5.1 - FI - Outpatient - Medicare Part B - Claims Processing

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

All charges, except for therapies, *telehealth originating site facility fee,* PPV, influenza virus vaccine, hepatitis B vaccine and hospital-based ambulance services are combined and reported under revenue code 0510 (clinic visit) on TOB 13X (hospital outpatient).

Regardless of the number of times a patient is seen in a given day at a particular IHS provider, the outpatient services should be billed only once (i.e., all-inclusive). An exception is when a patient is seen for a clinic visit, then returns to the emergency room later on the same day, at the same provider, for an unrelated condition (or vice versa). Two clinic visits may be billed in this instance. The remarks section of the bill shall include a narrative describing the situation and why two clinic visits are being billed. When a medical visit and an emergency visit occur on the same day, condition code G0 (distinct medical visit) shall be reported on the claim.

See Chapter18, §10 of Pub. 100-04, Medicare Claims Processing Manual, for detailed billing instructions for vaccines. Chapter 12 of Pub. 100-04 contains detailed billing instructions for outpatient therapy services provided by an occupational or physical therapist. See Chapter15 of Pub. 100-04 for detailed billing instructions for ambulance services.

The MSN is suppressed.

100.7.2.1 - FI - CAH Ancillary Services - Medicare Part B - Claims Processing

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

All charges, except therapies, *telehealth originating site facility fee,* PPV, influenza virus and hepatitis B vaccines are combined and reported under revenue code 024X (all-inclusive ancillary) on TOB 12X (hospital inpatient Part B). The MSN is suppressed.

See §§100.10 and 100.11 of this chapter, for more information on the payment of vaccines and their administration and therapy services.

100.9.1 - FI - CAH Outpatient - Medicare Part B - Claims Processing

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

All charges, except therapies, *telehealth originating site facility fee,* PPV, influenza virus vaccine, hepatitis B vaccine, and hospital-based ambulance services are combined and reported under revenue code 0510 (clinic visit) on TOB 85X (CAH).

Non-patient lab specimens are billed on TOB 14X (hospital other).

The MSN is suppressed.

See Chapter18, §10 of Pub. 100-04, Medicare Claims Processing Manual, for detailed billing instructions for vaccines. See Chapter 5 of Pub. 100-04 for detailed billing instructions for therapy services. See Chapter15 of Pub. 100-04 for detailed billing instructions for ambulance services.

100.16 –FI--Payment for Telehealth Services to Indian Health Service/Tribal Facilities and Practitioners

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

For background on the telehealth benefit, see Chapter 12, §190.1 in this manual. For more information on the payment of Telehealth services, see Chapter 15 of the Benefit Policy Manual. Telehealth services fall into two categories: an originating site facility service in which the beneficiary is presented to the distant site practitioner, and a distant site service which is generally some type of professional consultation.

100.16.1 – FI – Telehealth Originating Site Facility Fee – Medicare Part B – Payment Policy

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

Effective January 1, 2009, IHS providers, including CAHs are paid separately from the AIR for the Telehealth Originating Site Facility Fee. HCPCS code Q3014 ("telehealth originating site facility fee") is a Part B benefit. The fee is updated each calendar year by the Medicare Economic Index announced in the annual Physician Fee Schedule Final Regulation.
IHS providers are paid for HCPCS code Q3014 at the fee schedule payment, not the provider's usual all-inclusive payment methodology (e.g., inpatient DRG or AIR or CAH per diem). For CAHs, the payment amount is 80 percent of the fee, not 101 percent of cost.

The Medicare Part B deductible and coinsurance apply to the Telehealth Originating Site Facility Fee, but are waived by the IHS.

100.16.2 – FI – Telehealth Originating Site Facility Fee – Medicare Part B – Claims Processing

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

The Telehealth Originating Site Facility Fee is reported on TOB 12X, 13X or 85X along with the revenue code 0780 and HCPCS code Q3014 as described in Chapter 12, Section 190 of Pub. 100-04, Medicare Claims Processing Manual.

No clinic visit shall be billed if this is the only service received. There is no requirement that a practitioner present the patient for interactive telehealth services.

The MSN is suppressed.

100.16.3 – FI -- Payment for Distant Site Practitioner Services

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

Distant site services are listed in §190.3 in Chapter 12 of this manual. These services are payable only by the FI to a Method II CAH. Payment is based on 80 percent of the MPFS. Deductible and coinsurance apply, but are waived by IHS.
The MSN is suppressed.