CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 167	**Date: February 6, 2013**
	Change Request 7900

Transmittal 164, dated November 30, 2012, is being rescinded and replaced by Transmittal 167 to include HCPCS code G0459 on the list of Medicare Telehealth services for CY 2013 to allow telehealth services previously reported by CPT code 90862 to inpatients to continue to be reported and to change the implementation date to January 25, 2013, as previously instructed by CMS. All other information remains the same.

SUBJECT: Expansion of Medicare Telehealth Services for CY 2013

I. SUMMARY OF CHANGES: This CR updates the list of Medicare telehealth services.

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: January 25, 2013 (Contractors shall implement this change request no later than January 25, 2013, as previously instructed by CMS.)

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	15/270.2/List of Medicare Telehealth Services

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 obliged 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. 100-02	Transmittal: 167	Date: February 6, 2013	Change Request: 7900

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SUBJECT: Expansion of Medicare Telehealth Services for CY 2013

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: January 25, 2013 (Contractors shall implement this change request no later than January 25, 2013, as previously instructed by CMS.)

I. GENERAL INFORMATION

A. Background: In the calendar year 2013 physician fee schedule final rule with comment period, CMS is adding 8 codes to the list of Medicare distant site telehealth services. Additionally, the 2013 Healthcare Procedure Coding System (HCPCS) update will replace several CPT procedure codes related to psychotherapy services. A number of these services are on the list of approved telehealth services. Therefore, CMS is also updating the list of Medicare telehealth services to reflect these coding changes for the 2013 HCPCS update. The established policy for these telehealth services has not changed. This CR also adds relevant policy instructions to the manuals regarding the addition of these codes.

B. Policy: CMS is adding the following services, CPT and HCPCS codes to the list of Medicare telehealth services for CY 2013:

- HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and brief intervention, 15 to 30 minutes)
- HCPCS code G0397 (Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and intervention greater than 30 minutes)
- HCPCS code G0442 (Annual alcohol misuse screening, 15 minutes)
- HCPCS code G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes).
- HCPCS code G0444 (Annual Depression Screening, 15 minutes).
- HCPCS code G0445 (high-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes).
- HCPCS code G0446 (annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes).
- HCPCS code G0447 (Face-to-face behavioral counseling for obesity, 15 minutes).

The following codes will be added to the list of telehealth services to replace codes that will be deleted for CY 2013.

- CPT codes 90832, 90833, 90834, 90836, 90837, 90838 to report individual psychotherapy services, reported with CPT codes 90804 – 90809 prior to CY 2013.

- CPT codes 90791, 90792 to report psychiatric diagnostic interview examination, reported with CPT code 90801 prior to CY 2013.

- HCPCS code G0459 to report telehealth services previously reported by deleted CPT code 90862 when furnished to inpatients. Services furnished to outpatients can be reported with appropriate E/M codes currently on the list of telehealth services.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
7900-02.1	For dates of service on or after January 1, 2013, contractors (local Part B carriers and/or A/B MACs) shall accept and pay the following codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ or GT modifier: G0396 – G0397; G0442 – G0447; G0459; 90832 – 90834; 90836 – 90838; 90791 – 90792.	X				X						
7900-02.2	For dates of service on or after January 1, 2013, contractors (local FIs and/or A/B MACs) shall accept and pay the following codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ or GT modifier by CAHs that have elected Method II on TOB 85X:	X			X							

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	G0396 – G0397; G0442 – G0447; G0459; 90832 – 90834; 90836 – 90838; 90791 – 90792.											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
7900-02.3	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 sites 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 the contractor's 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: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Chanelle Jones, 410-786-9668 or chanelle.jones@cms.hhs.gov (for Part B claims processing), Kathleen Kersell, 410-786-2033 or kathleen.kersell@cms.hhs.gov (for Part B claims processing), Ryan Howe, 410-786-3355 or ryan.howe@cms.hhs.gov (for policy) , Tracey Mackey, 410-786-5736 or tracey.mackey@cms.hhs.gov (for Part A claims processing).

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 do 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.

270.2 – List of Medicare Telehealth Services

(Rev. 167, Issued: 02-06-13, Effective: 01-01-13, Implementation: 01-25-13)

The use of a telecommunications system may substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services. These services are listed below.

Consultations (Effective October 1, 2001- December 31, 2009)

Telehealth consultations, emergency department or initial inpatient (Effective January 1, 2010)

Follow-up inpatient telehealth consultations (Effective January 1, 2009)

Office or other outpatient visits

Subsequent hospital care services (with the limitation of one telehealth visit every 3 days) (Effective January 1, 2011)

Subsequent nursing facility care services (with the limitation of one telehealth visit every 30 days) (Effective January 1, 2011)

Individual psychotherapy

Pharmacologic management *(Effective March 1, 2003)*

Psychiatric diagnostic interview examination (Effective March 1, 2003)

End stage renal disease related services (Effective January 1, 2005)

Individual and group medical nutrition therapy (Individual effective January 1, 2006; group effective January 1, 2011)

Neurobehavioral status exam (Effective January 1, 2008)

Individual and group health and behavior assessment and intervention (Individual effective January 1, 2010; group effective January 1, 2011)

Individual and group kidney disease education (KDE) services (Effective January 1, 2011)

Individual and group diabetes self-management training (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) (Effective January 1, 2011)

Smoking Cessation Services (Effective January 1, 2012)

Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services (Effective January 1, 2013)

Annual alcohol misuse screening (Effective January 1, 2013)

Brief face-to-face behavioral counseling for alcohol misuse (Effective January 1, 2013).

Annual Depression Screening (Effective January 1, 2013)

High-intensity behavioral counseling to prevent sexually transmitted infections (Effective January 1, 2013)

Annual, face-to-face Intensive behavioral therapy for cardiovascular disease (Effective January 1, 2013)

Face-to-face behavioral counseling for obesity (Effective January 1, 2013)

NOTE: Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation CPT codes for payment of office/outpatient or inpatient visits. Instead, physicians and practitioners are instructed to bill a new or established patient office/outpatient visit CPT code or appropriate hospital or nursing facility care code, as appropriate to the particular patient, for all office/outpatient or inpatient visits. For detailed instructions regarding reporting these and other telehealth services, see Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 190.3.

The conditions of payment for Medicare telehealth services, including qualifying originating sites and the types of telecommunications systems recognized by Medicare, are subject to the provisions of 42 CFR 410.78. Payment for these services is subject to the provisions of 42 CFR 414.65.