E. MEDICARE TELEHEALTH SERVICES FOR THE PHYSICIAN FEE SCHEDULE

1. Billing and Payment for Telehealth Services

   a. History

Prior to January 1, 1999, Medicare coverage for services delivered via a telecommunications system was limited to services that did not require a face-to-face encounter under the traditional model of medical care. Examples of these services included interpretation of an x-ray, or electrocardiogram, or electroencephalogram tracing, and cardiac pacemaker analysis.

Section 4206 of the BBA provided for coverage of, and payment for, consultation services delivered via a telecommunications system to Medicare beneficiaries residing in rural health professional shortage areas (HPSAs) as defined by the Public Health Service Act.

Additionally, the BBA required that a Medicare practitioner (telepresenter) be with the patient at the time of a teleconsultation. Further, the BBA specified that payment for a teleconsultation had to be shared between the consulting practitioner and the referring practitioner and could not exceed the fee schedule payment which would have been made to the consultant for the service furnished. The BBA prohibited payment for any telephone line charges or facility fees associated with the teleconsultation. We implemented this provision in the CY 1999 PFS final rule with comment period (63 FR 58814).

Effective October 1, 2001, section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement Protection Act of 2000 (Pub. L. 106-554) (BIPA) added a new section, 1834(m), to the Act which significantly expanded Medicare telehealth services. Section 1834(m)(4)(F)(i) of the Act defines Medicare telehealth services to include consultations, office visits, office psychiatry services, and any additional service specified by the Secretary, when delivered via a telecommunications system. We first implemented this provision in the CY 2002 PFS final rule CMS-1590-P 134 with comment period (66 FR 55246). Section 1834(m)(4)(F)(ii) of the Act required the Secretary to establish a process that provides for annual updates to the list of Medicare telehealth services. We established this process in the CY 2003 PFS final rule with comment period (67 FR 79988).

As specified in regulations at §410.78(b), we generally require that a telehealth service be furnished via an interactive telecommunications system. Under §410.78(a)(3), an interactive telecommunications system is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient and the practitioner at the distant site. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system. An interactive telecommunications system is generally required as a condition of payment; however, section 1834(m)(1) of the Act 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. As specified in regulations at §410.78(a)(1), store and forward means the asynchronous transmission of medical
information from an originating site to be reviewed at a later time by the practitioner at the distant site.

Medicare telehealth services may be furnished to an eligible telehealth individual notwithstanding the fact that the individual practitioner furnishing the telehealth service is not at the same location as the beneficiary. An eligible telehealth individual means an individual enrolled under Part B who receives a telehealth service furnished at an originating site. Under the BIPA, originating sites were limited under section 1834(m)(3)(C) of the Act to specified medical facilities located in specific geographic areas. The initial list of telehealth originating sites included the office of a practitioner, a critical access hospital (CAH), a rural health clinic CMS-1590-P 135 (RHC), a Federally qualified health center (FQHC) and a hospital (as defined in Section 1861(e) of the Act). More recently, section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110-275) (MIPPA) expanded the list of telehealth originating sites to include hospital-based renal dialysis centers, skilled nursing facilities (SNFs), and community mental health centers (CMHCs). In order to serve as a telehealth originating site, these sites must be located in an area designated as a rural health professional shortage area (HPSA), in a county that is not in a metropolitan statistical area (MSA), or must be an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.

Finally, section 1834(m) of the Act does not require the eligible telehealth individual to be presented by a practitioner at the originating site.

b. Current Telehealth Billing and Payment Policies

As noted previously, Medicare telehealth services can only be furnished to an eligible telehealth beneficiary in an originating site. An originating site is defined as one of the specified sites where an eligible telehealth individual is located at the time the service is being furnished via a telecommunications system. In general, originating sites must be located in a rural HPSA or in a county outside of an MSA.

The originating sites authorized by the statute are as follows:

- Offices of a physician or practitioner;
- Hospitals;
- CAHs;
- RHCs;
- FQHCs;
- Hospital-Based or Critical Access Hospital-Based Renal Dialysis Centers (including Satellites);
- SNFs; and
- CMHCs.

Currently approved Medicare telehealth services include the following:

- Initial inpatient consultations;
- Follow-up inpatient consultations;
Office or other outpatient visits;
Individual psychotherapy;
Pharmacologic management;
Psychiatric diagnostic interview examination;
End-stage renal disease (ESRD) related services;
Individual and group medical nutrition therapy (MNT);
Neurobehavioral status exam;
Individual and group health and behavior assessment and intervention (HBAI);
Subsequent hospital care;
Subsequent nursing facility care;
Individual and group kidney disease education (KDE);
Individual and group diabetes self-management training (DSMT); and
Smoking cessation services.

In general, the practitioner at the distant site may be any of the following, provided that the practitioner is licensed under State law to furnish the service via a telecommunications system:

- Physician;
- Physician assistant (PA);
- Nurse practitioner (NP);
- Clinical nurse specialist (CNS);
- Nurse-midwife;
- Clinical psychologist;
- Clinical social worker; and
- Registered dietitian or nutrition professional.

Practitioners furnishing Medicare telehealth services submit claims for telehealth services to the Medicare contractors that process claims for the service area where their distant site is located.

Section 1834(m)(2)(A) of the Act requires that a practitioner who furnishes a telehealth service to an eligible telehealth individual be paid an amount equal to the amount that the practitioner would have been paid if the service had been furnished without the use of a telecommunications system.

Distant site practitioners must submit the appropriate HCPCS procedure code for a covered professional telehealth service, appended with the –GT (Via interactive audio and video telecommunications system) or –GQ (Via asynchronous telecommunications system) modifier. By reporting the –GT or –GQ modifier with a covered telehealth procedure code, the distant site practitioner certifies that the beneficiary was present at a telehealth originating site when the telehealth service was furnished. The usual Medicare deductible and coinsurance policies apply to the telehealth services reported by distant site practitioners.

Section 1834(m)(2)(B) of the Act provides for payment of a facility fee to the originating site. To be paid the originating site facility fee, the provider or supplier where the eligible telehealth individual is located must submit a claim with HCPCS code Q3014 (Telehealth originating site
facility fee), and the provider or supplier is paid according to the applicable payment methodology for that facility or location. The usual Medicare deductible and coinsurance policies apply to HCPCS code Q3014. By submitting HCPCS code Q3014, the originating site certifies that it is located in either a rural HPSA or non-MSA county or is an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000 as specified in section 1834(m)(4)(C)(i)(III) of the Act.

As previously described, certain professional services that are commonly furnished remotely using telecommunications technology, but that do not require the patient to be present in-person with the practitioner when they are furnished, are covered and paid in the same way as services delivered without the use of telecommunications technology when the practitioner is in-person at the medical facility furnishing care to the patient. Such services typically involve circumstances where a practitioner is able to visualize some aspect of the patient's condition without the patient being present and without the interposition of a third person's judgment.

Visualization by the practitioner can be possible by means of x-rays, electrocardiogram or electroencephalogram tracings, tissue samples, etc. For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram tracing that has been transmitted via telephone (that is, electronically, rather than by means of a verbal description) is a covered physician's service. These remote services are not Medicare telehealth services as defined under section 1834(m) of the Act. Rather, these remote services that utilize telecommunications technology are considered physicians’ services in the same way as services that are furnished in-person without the use of telecommunications technology; they are paid under the same conditions as in-person physicians’ services (with no requirements regarding permissible originating sites), and should be reported in the same way (that is, without the –GT or –GQ modifier appended).

2. Requests for Adding Services to the List of Medicare Telehealth Services

As noted previously, in the December 31, 2002 Federal Register (67 FR 79988), we established a process for adding services to or deleting services from the list of Medicare telehealth services. This process provides the public with an ongoing opportunity to submit requests for adding services. We assign any request to make additions to the list of telehealth services to one of two categories. In the November 28, 2011 Federal Register (76 FR 73102), we finalized revisions to criteria that we use to review requests in the second category. The two categories are:

- **Category 1**: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. In reviewing these requests, we look for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. We also look for similarities in the telecommunications system used to deliver the proposed service, for example, the use of interactive audio and video equipment.
Category 2: Services that are not similar to the current list of telehealth services. Our review of these requests includes an assessment of whether the service is accurately described by the corresponding code when delivered via telehealth and whether the use of a telecommunications system to deliver the service produces demonstrated clinical benefit to the patient. In reviewing these requests, we look for evidence indicating that the use of a telecommunications system in delivering the candidate telehealth service produces clinical benefit to the patient. Submitted evidence should include both a description of relevant clinical studies that demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings, and a list and copies of published peer reviewed articles relevant to the service when furnished via telehealth. Our evidentiary standard of clinical benefit does not include minor or incidental benefits.

Some examples of clinical benefit include the following:

- Ability to diagnose a medical condition in a patient population without access to clinically appropriate in person diagnostic services;
- Treatment option for a patient population without access to clinically appropriate in-person treatment options;
- Reduced rate of complications;
- Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process);
- Decreased number of future hospitalizations or physician visits;
- More rapid beneficial resolution of the disease process treatment;
- Decreased pain, bleeding, or other quantifiable symptom; and
- Reduced recovery time.

Since establishing the process to add or remove services from the list of approved telehealth services, we have added the following to the list of Medicare telehealth services: individual and group HBAI services; psychiatric diagnostic interview examination; ESRD services with 2 to 3 visits per month and 4 or more visits per month (although we require at least 1 visit a month to be furnished in-person by a physician, CNS, NP, or PA in order to examine the vascular access site); individual and group MNT; neurobehavioral status exam; initial and follow-up inpatient telehealth consultations for beneficiaries in hospitals and skilled nursing facilities (SNFs); subsequent hospital care (with the limitation of one telehealth visit every 3 days); subsequent nursing facility care (with the limitation of one telehealth visit every 30 days); individual and group KDE; and individual and group DSMT (with a minimum of 1 hour of in-person instruction to ensure effective injection training), and smoking cessation services.

Requests to add services to the list of Medicare telehealth services must be submitted and received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. For example, requests submitted before the end of CY 2012 will be considered for the CY 2014 proposed rule. Each request for adding a service to the list of Medicare telehealth services must include any supporting documentation the requester wishes us to consider as we review the request. Because we use the annual PFS rulemaking process as a vehicle for making changes to the list of Medicare telehealth services, requestors should be
advised that any information submitted is subject to public disclosure for this purpose. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, we refer readers to the CMS Website at www.cms.gov/telehealth/.

3. **Submitted Request and Other Additions to the List of Telehealth Services for CY 2013**

We received a request in CY 2011 to add alcohol and/or substance abuse and brief intervention services as Medicare telehealth services effective for CY 2013. The following presents a discussion of this request, and our proposals for additions to the CY 2013 telehealth list.

**a. Alcohol and/or Substance Abuse and Brief Intervention Services**

The American Telemedicine Association submitted a request to add alcohol and/or substance abuse and brief intervention services, reported by CPT codes 99408 (Alcohol and/or substance (other than tobacco) abuse structured screening (for example, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes) and 99409 (Alcohol and/or substance (other than tobacco) abuse structured screening (for example, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes) to the list of approved telehealth services for CY 2013 on a category 1 basis.

We note that we assigned a status indicator of ‘‘N’’ (Noncovered) to CPT codes 99408 and 99409 as explained in the CY 2008 PFS final rule with comment period (72 FR 66371). At the time, we stated that because Medicare only provides payment for certain screening services with an explicit benefit category, and these CPT codes incorporate screening services along with intervention services, we believed that these codes were ineligible for payment under the PFS.

We continue to believe that these codes are ineligible for payment under PFS and, additionally, under the telehealth benefit. We do not believe it would be appropriate to make payment for claims using these CPT codes for the services furnished via telehealth, but not when furnished in person. Because CPT codes 99408 and 99409 are currently assigned a noncovered status indicator, and because we continue to believe this assignment is appropriate, we are not proposing to add these CPT codes to the list of Medicare Telehealth Services for CY 2013.

However, we created two parallel G-codes for 2008 that allow for appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services that are not furnished as screening services, but that are furnished in the context of the diagnosis or treatment of illness or injury. The codes are HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and brief intervention, 15 to 30 minutes) and HCPCS code G0397, (Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and intervention greater than 30 minutes). Since these codes are used to report comparable alcohol and substance abuse services under certain conditions, we believe that it would be appropriate to consider the ATA’s request as it applies to these services when appropriately reported by the G-codes. The ATA asked that CMS consider this request as a category 1 addition based on the similarities between
these services and CPT codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes). We agree that the interaction between a practitioner and a beneficiary receiving alcohol and substance abuse assessment and intervention services is similar to their interaction in smoking cessation services. We also believe that the interaction between a practitioner and a beneficiary receiving alcohol and substance abuse assessment and intervention services is similar to the assessment and intervention elements of CPT code 96152 (health and behavior intervention, each 15 minutes, face-to-face; individual), which also is currently on the telehealth list.

Therefore, we are proposing to add HCPCS codes G0396 and G0397 to the list of telehealth services for CY 2013 on a category 1 basis. Consistent with this proposal, we are also proposing to revise our regulations at §410.78(b) and §414.65(a)(1) to include alcohol and substance abuse assessment and intervention services as Medicare telehealth services.

b. Preventive Services

Under our existing policy, we add services to the telehealth list on a category 1 basis when we determine that they are similar to services on the existing telehealth list with respect to the roles of, and interactions among, the beneficiary, physician (or other practitioner) at the distant site and, if necessary, the telepresenter. As we stated in the CY 2012 proposed rule (76 FR 42826), we believe that the category 1 criteria not only streamline our review process for publically requested services that fall into this category, the criteria also expedite our ability to identify codes for the telehealth list that resemble those services already on this list.

During CY 2012, CMS added coverage for several preventive services through the national coverage determination (NCD) process as authorized by section 1861(ddd) of the Act. These services add to Medicare’s existing portfolio of preventive services that are now available without cost sharing under the Affordable Care Act. We believe that for several of these services, the interactions between the furnishing practitioner and the beneficiary are similar to services currently on the list of Medicare telehealth services. Specifically, we believe that the assessment, education, and counseling elements of the following services are similar to existing telehealth services:

- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse, reported by HCPCS codes G0442 (Annual alcohol misuse screening, 15 minutes) and G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes).
- Screening for depression in adults, reported by HCPCS code G0444 (Annual Depression Screening, 15 minutes).
- Screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling (HIBC) to prevent STIs, reported by 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 semiannually, 30 minutes).
- Intensive behavioral therapy for cardiovascular disease, reported by HCPCS code G0446 (Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes).
Intensive behavioral therapy for obesity, reported by HCPCS code G0447 (Face-to-face behavioral counseling for obesity, 15 minutes). We believe that the interactions between practitioners and beneficiaries receiving these services are similar to individual KDE services reported by HCPCS code G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour), individual MNT reported by HCPCS code G0270 (Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in the same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes); CPT code 97802 (Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes); and CPT code 97803 (Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes), and HBAI reported by CPT code 96150 (Health and behavior assessment (for example, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment); CPT code 96151 (Health and behavior assessment (for example, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient reassessment); CPT code 96152 (Health and behavior intervention, each 15 minutes, face-to-face; Individual); CPT code 96153 (Health and behavior intervention, each 15 minutes, face-to-face; Group (2 or more patients)); CPT code 96154 (Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)), all services that are currently on the telehealth list.

Therefore, we are proposing to add HCPCS codes G0442, G0443, G0444, G0445, G0446, and G0447 to the list of telehealth services for CY 2013 on a category 1 basis. We note that all coverage guidelines specific to the services would continue to apply when these services are furnished via telehealth. For example, when the national coverage determination requires that the service be furnished to beneficiaries in a primary care setting, the qualifying originating telehealth site must also qualify as a primary care setting. Similarly, when the national coverage determination requires that the service be furnished by a primary care practitioner, the qualifying primary distant site practitioner must also qualify as primary care practitioner. For more detailed information on coverage requirements for these services, we refer readers to the Medicare National Coverage Determinations Manual, Pub. 100-03, Chapter 1, Section 210, available at http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf. Consistent with this proposal, we are also proposing to revise our regulations at §410.78(b) and §414.65(a)(1) to include these preventive services as Medicare telehealth services.

4. **Technical Correction to Include Emergency Department Telehealth Consultations in Regulation**

In the CY 2012 PFS final rule with comment period (76 FR 73103), we finalized our proposal to change the code descriptors for initial inpatient telehealth consultation G-codes to reflect telehealth consultations furnished to emergency department patients in addition to inpatient telehealth consultations effective January 1, 2012. However, we did not amend the description of the services within the regulation at §414.65(a)(1)(i). Therefore, we are proposing to make a
technical revision to our regulation at §414.65(a)(1)(i) to reflect telehealth consultations furnished to emergency department patients in addition to hospital and SNF inpatients.

**CMS CONTACT:**

Ryan Howe, (410) 786-3355, for issues related to practice expense methodology and direct practice expense inputs, telehealth services, and issues related to primary care and care coordination.
12. Section 410.78 is amending by revising the introductory text of paragraph (b) to read as follows:

§410.78 Telehealth services.

(b) General rule. Medicare Part B pays for office or other outpatient visits, subsequent hospital care services (with the limitation of one telehealth visit every three days by the patient’s admitting physician or practitioner), subsequent nursing facility care services (not including the Federally-mandated periodic visits under §483.40(c) and with the limitation of one telehealth visit every 30 days by the patient’s admitting physician or nonphysician practitioner), professional consultations, psychiatric diagnostic interview examination, neurobehavioral status exam, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one “hands on” visit per month to examine the access site), individual and group medical nutrition therapy services, individual and group kidney disease education services, individual and group diabetes self-management training services (except for one hour of “hands on” services to be furnished in the initial year training period to ensure effective injection training), individual and group health and behavior assessment and intervention services, smoking cessation services, alcohol and/or substance abuse and brief intervention services, screening and behavioral counseling interventions in primary care to reduce alcohol misuse, screening for depression in adults, screening for sexually transmitted infections (STIs) and high intensity behavioral counseling (HIBC) to prevent STIs, intensive behavioral therapy for cardiovascular disease, and behavioral counseling for obesity furnished by an interactive telecommunications system if the following conditions are met:

16. Section 414.65 is amended by revising paragraph (a)(1) to read as follows:

§414.65 Payment for telehealth services.

(a) * * *

(1) The Medicare payment amount for office or other outpatient visits, subsequent hospital care services (with the limitation of one telehealth visit every 3 days by the patient’s admitting physician or practitioner), subsequent nursing facility care services (with the limitation of one telehealth visit every 30 days by the patient’s admitting physician or nonphysician practitioner), professional consultations, psychiatric diagnostic interview examination, neurobehavioral status exam, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one “hands on” visit per month to examine the access site), individual and group medical nutrition therapy services, individual and group kidney disease education services, individual and group diabetes self-management training services (except for one hour of “hands on” services to be furnished in the initial year training period to ensure effective injection training), individual and group health and behavior assessment and intervention, smoking cessation services, alcohol and/or substance abuse and brief intervention services, screening and behavioral counseling interventions in primary care to reduce alcohol misuse, screening for depression in adults, screening for sexually transmitted infections (STIs) and high intensity behavioral counseling (HIBC) to prevent STIs, intensive behavioral therapy for cardiovascular disease, and behavioral counseling for obesity furnished
via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

(i) Emergency department or initial inpatient telehealth consultations. The Medicare payment amount for emergency department or initial inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to initial hospital care provided by a physician or practitioner.

(ii) Follow-up inpatient telehealth consultations. The Medicare payment amount for follow-up inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to subsequent hospital care provided by a physician or practitioner.

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