Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, September 8, 2016
9:00 a.m. to 12:00 a.m.
Location: HealthPartners, 8170 Building, Bloomington, St. Croix – 1st floor

Webex Information

Teleconference Information:

Call-in line: 1-712-832-8300

Participant Access Code: 337213#

Callers are responsible for any long distance charges.

1. To start the webex session, go to: https://health-state-mn-ustraining.webex.com.
2. Under "Attend a Session "click "Live Sessions"
3. Click on the session for "AUC Medical Code TAG"
4. Provide your name, email address, and the following password: Mct2010! (Note: the password must be typed in; it cannot be cut and pasted. The exclamation point is part of the password)
5. Click "Join now"

1. **Welcome and Introductions**
   - **Attendance tracking: Deb Sorg** deb.a.sorg@healthpartners.com
   - **Membership request and/or updates: Deb Sorg** deb.a.sorg@healthpartners.com
2. **Review of Antitrust Statement**
3. **Review of last meeting's minutes** – July 14, 2016
4. **Community Emergency Medical Technician Services – Shawnet Healy, DHS**

4/14/16: Shawnet Healy presented information on an upcoming SBAR. She will build an SBAR for review. The legislated effective date is expected to be 1/1/2017. The service starts with a request from the primary practitioner to the EMT. The EMT visits the patient's home to check on/assess the patient including performing minor vitals. These services by the EMT has been shown to reduce patient readmissions. The billing would be done the same as the Community Paramedic; however, the EMT has a higher scope of practice. The anticipated code would be T1028.	OPEN
5/12/16: Waiting for SBAR.	OPEN
6/9/16: Do not have official SBAR. Shawnet distributed current legislative language; will need to be approved by CMS. Working with federal lawyers for submission to CMS. Trying to determine to use T1028 or T1016. T1028 appears to be more appropriate (assessment of home, physical and family environment to determine suitability to meet patient's medical needs) – fits services EMTs perform most. The modifier is being discussed at DHS and will be used to identify that services was provided by EMT. Billing is 15-minute increments. Will confirm if modifier is needed to identify billing units. No travel, no mileage; only face-to-face time	OPEN
7/14/16: Shawnet stated that the CEMT is authorized to provide two types of services, a safety home check for repeated fall calls and discharge review for nursing home and hospital patients. She further explained that CEMT visits for nursing home and hospital discharges are limited to one visit and that CEMTs will perform a safe home check and patient discharge services at the same time for nursing home discharge review. The TAG discussed the CEMT SBAR and determined that an additional modifier is required to describe the 15-minute unit for CEMT services provided because HCPCS T1028 is not a timed based code. One of	OPEN

the members stated that where there is no time verbiage in the description, it is one per day. DHS agreed that an additional modifier is needed and recommended use of UD for the 15 minute unit. The MCT agreed and voted to approve T1028 U2 UD. However, Shawnet will revise the SBAR. It was also suggested to revise the table in the 837P to Medicaid only or move CEMT entry to DHS only program. This issue will be discussed and resolved at future MCT meetings	

5. Protected Transport - DHS

5/12/16: Waiting for SBAR.	OPEN
6/9/16: Questions regarding whether requirements have changed for ATS (Common Carrier) and STS (special transportation services) or this is a new transportation service. Send any additional questions to Kathy Sijan at @katherine.sijan@state.mn.us	OPEN
7/14/16: The TAG reviewed the revised coding spreadsheet for these services and voted to approve recommendation. The SBAR will be completed and sent out to TAG for an email vote. The disposition requested is to place in the coding recommendation table and move to 837P companion guide during the next maintenance process. One of the members stated DHS had a training webinar for providers posted on their website and suggested members view if for additional information regarding the new services for this program.	OPEN Faith will request MCT's approval via email vote.

6. Telemedicine – JoAnne Wolf, Children's Health Network

The expanded telemedicine benefit is a legislated benefit effective for state public programs 1/1/16 and then is effective for commercial plans on 1/1/17. I think we need to make sure we have some coding guidelines for this service or if using the telemedicine modifiers on an E/M would work. POS might be an issue though since the patient could be located anywhere (home, work, etc.) not just at a host facility.

7. Telehealth Place of Service (POS) – Barb Andreasen, Allina Health – see SBAR

8. DHS and Companion Guide Maintenance – David Haugen, MDH

AUC Executive Committee discussed the increasing challenges of synchronizing DHS-specific information with the companion guide maintenance process, as evidenced by the lengthy maintenance process this year and the need to revote the guide as a result of the ARMHS changes. The Exec Committee agreed to include the issue on the agenda for the September Operations meeting for review and discussion.

9. Coding Recommendation Grid Update Criteria – Judy Edwards, MDH

To assure consistency and timeliness, criteria for updating the Coding Recommendation Grid needs to be developed. Should a TAG vote be required to update the grid each time an SBAR response is approved by the AUC before updating the website? How often should we update the grid and post to the website?

10. Decision Tree Creation Reminder– Judy Edwards, MDH

TAG members need to create a decision tree for SBARs and present for discussion and approval.

11. Additional Agenda Items/ Announcements

- Next regularly scheduled meeting: October 13, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington.
- *AUC UPDATE* newsletter coding article volunteer.

MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Meeting Minutes – Thursday July 14, 2016

Draft

Agenda Item	Discussion	Action Item
1. Welcome and Introductions, Attendance tracking: Deb Sorg deb.a.sorg@healthpartners.com, **Membership request and/or updates: Deb Sorg** deb.a.sorg@healthpartners.com	Faith convened meeting and members introduced themselves. Since there was not attendance sign-in sheet, Faith requested all members, including those attending meeting in person, to notify Deb Sorg via email at @deb.a.sorg@healthpartners.com	
2. Review of Antitrust Statement	Faith read AUC anti-trust statement.	
3. Review of last meeting's minutes – June 9, 2016	TAG reviewed and voted to approve June 9 meeting minutes as presented.	Closed
4. AUC Coding Recommendation Table Review	The coding recommendation was sent to TAG members for their review and recommended changes prior to today's meeting No one had any changes to the current draft. The draft was reviewed and approved by the MCT.	Closed MDH will forward recommendation table along with any outstanding SBARs to be fused.
5. Community Emergency Medical Technician Services – Shawnet Healy, DHS	Shawnet stated that the CEMT is authorized to provide two types of services, a safety home check for repeated fall calls and discharge review for nursing home and hospital patients. She further explained that CEMT visits for nursing home and hospital discharges are limited to one visit and that CEMTs will perform a safe home check and patient discharge services at the same time for nursing home discharge review. The TAG discussed the CEMT SBAR and determined that an additional modifier is required to describe the 15-minute unit for CEMT services provided because HCPCS T1028 is not a timed based code. One of the members stated that where there is no time verbiage in the description, it is one per day. DHS agreed that an additional modifier is needed and recommended use of UD for the 15 minute unit. The MCT agreed and voted to approve T1028 U2 UD. However, Shawnet will revise the SBAR. It was also suggested to revise the table in the 837P to Medicaid only or move CEMT entry to DHS only program. This issue will be discussed and resolved at future MCT meetings.	OPEN
6. Protected Transport - DHS	The TAG reviewed the revised coding spreadsheet for these services and voted to approve recommendation. The SBAR will be completed and sent out to TAG for an email vote.	OPEN Faith will request MCT's approval via email vote.

	The disposition requested is to place in the coding recommendation table and move to 837P companion guide during the next maintenance process. One of the members stated DHS had a training webinar for providers posted on their website and suggested members view if for additional information regarding the new services for this program.	
7. SBAR - Compulsive Gambling - Richard Scherer, Club Recovery, LLC	MDH reported the SBAR has been withdrawn by the submitter.	Closed
8. SBAR ARMHS – Modifier Changes, Kathy Sijan, DHS	DHS submitted an SBAR asking the AUC to consider incorporating corrections for ARMHS services in version 12 of the 837P companion guide, which is scheduled to be published in the August 1 Minnesota State Register. Whether to incorporate the changes now was discussed at Monday, July 11 Executive Meeting. The Exec Committee deferred the decision to consider the corrected changes as technical to the MCT for their review and recommendation. TAG reviewed the request to define the current modifier U3 to transition to community living (TCL) and redefine modifier UD when used with H0031 and H0032 as per 15 minutes. The Medical Code TAG determined that the request was technical changes and approved the SBAR, with two no votes. The guide will be revised and resubmitted to the MDH Commissioner for approval and then published in the Minnesota State Register. MDH will convey MCT voting results to the AUC Executive and determine if Ops need to vote again or just notified of the change. Should we include language re: DHS programs to remind users to refer to DHS website for most recent and accurate coding or remove DHS information with link to DHS web site? That may be discussed as a separate future issue.	Closed
9. Additional Agenda Items/ Announcements	• Birthing Center POS question: MCT was asked by one of its members to confirm that place of service for birthing center is 25. The correct place of service (POS) for birthing center is an issue currently being discussed within her organization. After reviewing the companion guides and definition of licensed birthing center, it was agreed that POS 25 is correct. • Sheryl Theno announced that MCT member Judith Blyth is retiring	Closed

	effective August 4 and on behalf on Judith stated that Judith enjoyed working with the MCT. • Next regularly scheduled meeting: August 11, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington. • *AUC UPDATE* newsletter coding article volunteer.	

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH			
Date Received:	**Log No.:**	**Date Closed:**	
Date Sent to AUC Executive Committee:	**Date Sent to AUC TAG Co-chair(s):**	**TAG Recommendation:** _____ Accept _____ Reject	**Date Decision Sent to Originator:**

REMINDER: After completing sections I and II, submit to the AUC inbox at health.AUC@state.mn.us. The Medical Code TAG Decision Tree form must be completed for medical coding issues and submitted with the SBAR. It is recommended that the Decision Tree form be completed first.

Section I – SBAR Short Title, Date, and Contact information (Person submitting the SBAR and/or Subject Matter Expert). All fields must be completed. Incomplete forms will be returned to the submitter.

SBAR Short title (Required): CEMT provider type legislation 256B.0625, sec. 13, subd. 60a	Version #: 2	Date submitted to AUC (Required): 7-15-16
Contact Information for person completing this form (Required): Name: Shawnet Healy Title: MN DHS Benefit Policy Specialist Email address: Shawnet.healy@state.mn.us Telephone: 651.431.3721	Organization Information (Required): Name: MN DHS – Andersen Bldg. Address: 540 Cedar St. St. Paul, MN 55101	

SBAR presenter, if different from above:
Name: Shawnet Healy
Title:Benefit Policy Specialist
Email address: Shawnet.healy@state.mn.us
Phone number: 651.431.3721

Please note: The SBAR presenter must be in attendance or available during the meeting(s) in order for the SBAR to be discussed. You will received notification from the TAG co-chair with the meeting date and time when the SBAR will be discussed.

Section II – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation). Each letter must be completed before the SBAR will receive consideration.

SBAR Issue Title: Community Emergency Medical Technicians (CEMTs) as new provider type in MN

S	**SITUATION** – Currently there is no other provider type that is doing what the CEMTs will be doing.
B	**BACKGROUND** – CEMTs will be addressing the needs of recipients, such as going over their discharge orders, meds check, and safe home check • **hospital discharges-**

	The patient's physician (hospitalist or primary care) orders the post-hospital discharge visit. The visit is included in the patient's care plan. Included components: • Provide verbal or visual reminders of discharge orders • Recording and reporting of vital signs to the patient's primary care provider • Medication access confirmation • Food access confirmation • Identification of home hazards • **For nursing home discharges or repeated fall calls-** Primary care would coordinate and be responsible for the treatment plan ordering the CEMT services. • Circumstances that may trigger a safety evaluation visit: o Repeat ambulance calls due to falls o Nursing home discharges o Individuals identified by primary care as at risk for nursing home placement • Included components: o Medication access confirmation o Food access confirmation o Identification of home hazards ## Community Emergency Medical Technician Services ### II. Legislation Minnesota Session Laws 2015, Chapter 71, Article 9, **Sec. 18. COMMUNITY MEDICAL RESPONSE EMERGENCY MEDICAL TECHNICIAN SERVICES COVERED UNDER THE MEDICAL ASSISTANCE PROGRAM.** https://www.revisor.mn.gov/laws/?id=189&doctype=Chapter&year=2016&type=0#laws.19.13.0
A	**ASSESSMENT** – Currently there is no provider type to do these home visits post hospital discharge, or when someone is returning home from a nursing home, or when someone has had repeated home calls by paramedics/ambulance services for falls and a 'safe home' check is needed. This provider type is to assist in reducing readmission and it is working. This is addressing the first 24-48 hours post discharge to go over the discharge orders from the primary provider, confirm the recipient has the necessary meds, their food supply is checked and the home is safe. This will be billed by the medical director for the ambulance service in units of 15 minutes. A CEMT must use at least eight minutes of a unit in order to bill it
R	**RECOMMENDATION** – Recommending T1028 for a code with a specific U2 modifier to denote a CEMT did the visit. These visits take 1-2 15 minute units, in the home with a second unit requiring a minimum of 8 minutes be used to bill for the second unit. The UD Modifier will be needed to denote 15 minute increments. Pilot program in St. Louis Park that included 4 other communities was very successful in reducing readmits. The effective date is 1.1.17 or upon federal approval, whichever is later. Recommending this be in the MUCG, 837P **CODE | Mod1 | Mod2** T1028 –U2 -UD - Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs, CEMT, per 15 minutes .

Section III – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; coding issue addressed or SBAR issue title; whether TAG accepted or rejected recommendation requested in SBAR; explanation or basis for TAG decision and SBAR response will be placed in recommendation grid or companion guide):

Date [SBAR Response Approved by TAG]:

Reviewed by [AUC TAG Name]:

AUC Co-Chair(s):

Discussion/Summary:

Key Findings and Recommendation(s):

Disposition status *(e.g., Minnesota Uniform Companion Guide or Best practice)*:

Decision Summary:

AUC Response:

The findings and recommendations above were also reviewed and _____ by the AUC.

AUC Approval Date:

Administrative Uniformity Committee

SBAR New NEMT service: Protected Transport and other transportation changes

AUC BUSINESS NEED EXPLANATION FORM (SBAR)
TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH

Date Received: May 12, 2016	Log No.: 2016-010	Date Closed	
Status: Exec Review Date: May 12, 2016	**Sent to TAG/WG:** May 12, 2016	**TAG Recommendation:** _____ Accept _____ Reject	**Decision to Originator**

REMINDER: Submit the completed SBAR and MCT Decision Tree form via email to the AUC at health.AUC@state.mn.us. The MCT Decision Tree is completed for medical coding issues only.

Section I – SBAR Short Title, Date, and Contact information (Person submitting the SBAR and/or Subject Matter Expert)

SBAR Short title: Protected Transport	Date: 5-9-2016
Contact Information for person completing this form: **Name:** Katherine Sijan **Title:** HealthCare Coding Compliance Officer **Email address:** Katherine.sijan@state.mn.us **Telephone:** 651-431-5784	**Organization Information:** **Name:** MN Dept of Human Services **Address:** 540 Cedar St., 7th fl -0993 St Paul, MN 55155

Section II – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation)

SBAR Issue Title:

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed: On 7-1-2016, the medical transportation services that DHS currently classifies as access transportation services (ATS) which is administered by the counties/tribes along with special transportation services (STS) administered by the state will change to add a new service, called protected transport.
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): Minnesota Statute 256B.0625, Subd. 17 thru 17b and 18 thru 18h, contains the full range of information related to this legislation that has changed to add 'protected transport. Subdivisions 17 thru 17b contain the real information related to the transports. Part of this change will require all NEMT providers to be STS certified by MnDOT unless they are a publically operated transit system, a volunteer driver, or "not for hire vehicle" (personal mileage). [Subd. 17, Item (c)]
A	**ASSESSMENT** – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): The change will include a change in transport service definitions and a new transportation type referenced as "protected transport".

	Transport services as a whole will be referenced as "non-emergency medical transportation" or "NEMT". With that change in terminology, the current classification of "ATS" will change and be referenced as "**County/Tribal Administered NEMT**". Also, what is currently the "STS" transports will be referenced as "**State Administered NEMT**". Part of this change in terminology is based on statute and the common language used by the "Non-Emergency Medical Transportation Advisory Committee". These changes are effective on 7-1-2016.
R	**RECOMMENDATION** – What are you recommending, including any known timing that needs to be considered: **RE: Coding and billing; these changes will be as follows:** - The state modifiers that are currently used that **will continue to be used** for the County/Tribal NEMT transports for dates-of-service on/after 7-1-2016 are the following: o **UC** modifier will continue to be used with the A0090 (personal mileage) service code to indicate a higher mileage reimbursement rate licensed foster parents o **U2** modifier will continue to be used with the S0215 (ambulatory mileage) service code to indicate the mileage payment rate for county/tribal NEMT transports billed with the A0100 (taxi/dial-a-ride) county/tribal service code as part of "unassisted transport" o **U7** modifier will continue to be used with the A0110 (bus/light rail) county/tribal service code to indicate reimbursement for a "monthly" bus/light rail pass as part of the county/tribal NEMT transports included in the "unassisted transport" type - - The state **modifiers that will end with the last date-of-service 6-30-2016** for the county/tribal current ATS transports include: o **U4** modifier will no longer be needed for use with the A0100 transport county/tribal service code for "taxi/dial-a-ride, ambulatory, door-to-door" o **U5** modifier will no longer be needed for use with the A0100 transport county/tribal service code for "taxi/dial-a-ride, wheelchair, curb-to-curb" o **U6** modifier will no longer be needed for use with the A0100 transport county/tribal service code for "taxi/dial-a-ride, wheelchair, door-to-door" o **U2** modifier will no longer be needed for use with the S0209 mileage county/tribal service code for "taxi/dial-a-ride, wheelchair" **The following represents the new benefit for "protected transport"**, part of the State Administered NEMT services, and effective for dates-of-service on/after 7-1-2016. This is a new transport type for MHCP and there are no service (base/pickup) or mileage codes for this transport type. **The single modifier will be used with both the following codes for the base/pickup and mileage charges**: o **T2003 UA-** Nonemergency transportation; encounter/trip, Protected Transport -service code and state modifier will identify the transport base/pick-up billing for protected transport o **S0215 UA -**Nonemergency transportation; mileage, per mile, Protected Transport -service code and state modifier will identify the mileage billing for protected transport

Section III – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; coding issue addressed or SBAR issue title; whether TAG accepted or rejected recommendation requested in SBAR; explanation or basis for TAG decision and SBAR response will be placed in recommendation grid or companion guide):
Date [SBAR Response Approved by TAG]: Reviewed by [AUC TAG Name]: AUC Co-Chair(s): AUC Response: **Discussion/Summary:** **Decision:**

Non Emergency Medical Transport [NEMT]

New Service: Protected Transport - effective 7-1-2016

Procedure Code / U MOD	HCPCS Description	DHS Description
T2003 UA	Nonemergency transportation; encounter/trip	Nonemergency transportation; encounter/trip, Protected Transport
S0215 UA	Nonemergency transportation; mileage, per mile	Nonemergency transportation; mileage, per mile, Protected Transport

Access Transportation Services [ATS}- Ending 6/30/16

Procedure Code / U MOD	HCPCS Description	DHS Description
A0100 U4	Nonemergency transportation; taxi	County/tribal service code for "taxi/dial-a-ride, ambulatory, door-to-door"
A0100 U5	Nonemergency transportation; taxi	County/tribal service code for "taxi/dial-a-ride, wheelchair, curb-to-curb"
A0100 U6	Nonemergency transportation; taxi	County/tribal service code for "taxi/dial-a-ride, wheelchair, door-to-door"
S0209 U2	Wheelchair van, mileage, per mile	Non-emergency transportation; wheelchair van, mileage per mile

No Change to any of the following services;
-County/Tribal Administered NEMT *[formerly known as ATS - Access Transportation Services thru 6-30-16*] and
-State Administered NEMT [*formerly known as STS - Special Transportation Services thru 6-30-16*]

Procedure Code / U MOD	HCPCS Description	DHS Description
A0080	Nonemergency transportation, per mile – volunteer driver	Volunteer driver mileage reimbursement
A0090 UC	Nonemergency transportation, per mile - Licensed foster parent - vehicle provided by individual licensed foster parent	Personal mileage reimbursement, licensed foster parent
A0100	Nonemergency transportation; taxi	Unassisted Transport Base/Pickup (Taxi/dial-a-ride for county/tribe Administered NEMT)

No Change to any of the following services; **-County/Tribal Administered NEMT** *[formerly known as ATS - Access Transportation Services thru 6-30-16*] and **-State Administered NEMT** [*formerly known as STS - Special Transportation Services thru 6-30-16*]		
A0110	Nonemergency transportation and bus, intra- or interstate carrier	Bus/Light Rail
A0110 U7	Nonemergency transportation and bus, intra- or interstate carrier	Bus/light rail monthly pass
A0120	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems	ADA paratransit
A0130	Nonemergency transportation: wheelchair van	Ramp/lift Equipped Vehicle Base/Pickup (Wheelchair transport for State Administered NEMT)
A0140	Nonemergency transportation and air travel (private or commercial) intra- or interstate	Air travel
S0209	Wheelchair van, mileage, per mile	Mileage Ramp/Lift Equipped Vehicle
S0215	Nonemergency transportation, encounter/trip; mileage, per mile	Thru 6/30/16: STS ambulatory mileage Effective 7/1/16: State administered NEMT assisted transport mileage
S0215 U2	Nonemergency transportation; mileage, per mile	Mileage unassisted transport
T2001	Nonemergency transportation; patient attendant/escort	Extra Attendant – Stretcher
T2003	Nonemergency transportation, encounter/trip	Thru 6/30/16: STS ambulatory mileage Effective 7/1/16: State administered NEMT assisted transport mileage
T2005	Nonemergency transportation; stretcher van	Stretcher Transport Base/Pickup (State Administered NEMT)
T2049	Nonemergency transportation; stretcher van, mileage; per mile	Mileage Stretcher Transport

DHS Telemedicine Services

All Telemedicine

DHS link:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_008926

Telemedicine is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site.
Link:

To be eligible for reimbursement, providers must self-attest that they meet all of the conditions of the MHCP telemedicine policy by completing the Provider Assurance Statement for Telemedicine (DHS-6806) (PDF).

Effective Jan. 1, 2016, MHCP allows payment for expanded telemedicine services. Payment is allowed for the following services:

- Interactive audio and video telecommunications that permit real-time communication between the distant site physician or practitioner and the recipient. The services must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face encounter.
- **"Store and Forward":** The asynchronous transmission of medical information to be reviewed at a later time by a physician or practitioner at the distant site. Medical information may include, but is not limited to, video clips, still images, x-rays, MRIs, EKGs, laboratory results, audio clips and text. The physician at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time.

Originating Site

The originating site is the location of an eligible MHCP recipient at the time the service is being furnished via a telecommunication system. Authorized originiating sites are listed below:

- Office of physician or practitioner
- Hospital (inpatient or outpatient)
- Critical access hospital (CAH)
- Rural health clinic (RHC) and Federally Qualified Health Center (FQHC)
- Hospital-based or CAH-based renal dialysis center (including satellites)
- Skilled nursing facility (SNF)
- End-stage renal disease (ESRD) facilities
- Community mental health center
- Dental clinic
- Residential facilities, such as a group home and assisted living
- Home (a licensed or certified health care provider may need to be present to facilitate the delivery of telemedicine services provided in a private home)
- School

Eligible Providers

The following provider types are eligible to provide telemedicine services:

- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Clinical nurse specialist
- Registered dietitian or nutrition professional
- Clinical psychologist
- Clinical social worker
- Dentist, dental hygienist, dental therapist, advanced dental therapist
- Pharmacist
- Certified genetic counselor
- Podiatrist
- Speech therapist
- Physical therapist
- Occupational therapist
- Audiolgist

Eligible Recipients

Telemedicine coverage applies to MHCP recipients in fee-for-service programs. Prepaid health plans may or may not choose to pay for services delivered in this manner.

List of Telemedicine Services

The CPT and HCPC codes that describe a telemedicine service are generally the same codes that describe an encounter when the health care provider and patient are at the same site. Examples of telemedicine services include but are not limited to the following:

- Consultations
- Telehealth consults: emergency department or initial inpatient care
- Subsequent hospital care services with the limitation of one telemedicine visit every 30 days per eligible provider
- Subsequent nursing facility care services with the limitation of one telemedicine visit every 30 days
- End-stage renal disease services
- Individual and group medical nutrition therapy
- Individual and group diabetes self-management training with a minimum of one hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training
- Smoking cessation
- Alcohol and substance abuse (other than tobacco) structured assessment and intervention services

Billing Telemedicine Services

MHCP enrolled providers submit claims for telemedicine services using the CPT or HCPC code that describes the services rendered. The following modifiers must also be included:

- **GT** (via interactive audio and video telecommunications systems)
- **GQ** (via asynchronous telecommunication system)

When reporting a service with the GT modifier, the provider is certifying that they are rendering services to a patient located in an eligible originating site via an interactive audio and visual telecommunications system

General

In addition to other requirements, refer to the following general telemedicine information:
• Out-of-state coverage policy applies to services provided via telemedicine. Consultations performed by providers who are not located in Minnesota and contiguous counties, require authorization prior to the service being provided
• Payment will be made for only one reading or interpretation of diagnostic tests such as x-rays, lab tests, and diagnostic assessments
• Payment is not available to providers for sending materials to recipients, other providers or facilities

Two-Way Interactive Video Consultation in an Emergency Room (ER)

Two-way interactive video consultation may be billed when no physician is in the ER and the nursing staff is caring for the patient at the originating site. The ER physician at the distant site bills the ER CPT codes with the GT modifier. Nursing services at the originating site would be included in the ER facility code.
If the ER physician requests the opinion or advice of a specialty physician at a "hub" site, the ER physician bills the ER CPT codes without the GT modifier. The consulting physician bills the consultation E/M code with the GT modifier.

Coverage Limitations

The following limitations apply:

- Payment for telemedicine services is limited to **three** per week per recipient
- Payment is not available for sending materials to a recipient, other provider or facility

The following are not covered under telemedicine:

- Electronic connections that are not conducted over a secure encrypted website as specified by the Health Insurance Portability & Accountabiliyt Act of 1996 Privacy & Security rules (e.g., Skype)
- Prescription renewals
- Scheduling a test or appointment
- Clarification of issues from a previous visit
- Reporting test results
- Non-clinical communication
- Communication via telephone, email or facsimile

	Procedure code	Modifiers	Service Name	Type of Service	Link to DHS Provider Manual
1	0359T	UB AM GT	Comprehensive Multi-Disciplinary Evaluation (CMDE) – Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
2	0359T	UB TG GT	Comprehensive Multi-Disciplinary Evaluation (CMDE) – Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
3	0359T	UB HP GT	Comprehensive Multi-Disciplinary Evaluation (CMDE) – Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
4	0359T	UB HO GT	Comprehensive Multi-Disciplinary Evaluation (CMDE) – Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
5	0362T / 0363T	UB HK GT	Intervention Observation and Direction: Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
6	0362T / 0363T	UB HP GT	Intervention Observation and Direction: Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
7	0362T / 0363T	UB HO GT	Intervention Observation and Direction: Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
8	0362T / 0363T	UB HN GT	Intervention Observation and Direction: Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
9	0362T / 0363T	UB HN GT	Intervention Observation and Direction: Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
10	T1027	UB HK GT	Family/Caregiver Training and Counseling: Individual-Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
11	T1027	UB HP GT	Family/Caregiver Training and Counseling: Individual-Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
12	T1027	UB HO GT	Family/Caregiver Training and Counseling: Individual-Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
13	T1027	UB HN GT	Family/Caregiver Training and Counseling: Individual-Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
14	T1027	UB HN GT	Family/Caregiver Training and Counseling: Individual-Telemedicine	EIDBI	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195658
15	CPT or HCPCS	GT	Mental health outpatient services **NOTE:** Use the place of service code that identifies the location of the recipient when the service was provided.	Mental Health	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_160257#bill
16	T1018	U1 TM GT	Some IEP Services [Individualized Education Plan] **NOTE**: Distant Site The distant site is the location where the licensed health care provider is located while providing the service via telemedicine.	IEP	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_185201#criteria
17	T1013	GT	Interpreter Services	Interpreter	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_157632
18	Limited list- see link to statute	U9 GT	Telemedicine for Dental Services [256B.0625, subdivision 9]	Dental	https://www.revisor.mn.gov/statutes/?id=256B.0625

Type of Telemedicine	Coding	Reimbursement/Coverage Policy			
		DHS	Medica	HealthPartners	BCBS of MN
Telephone Care	99441-99443 - Physician/NP/PA 98966-98968 - Non-Physician	Not covered per MHCP Provider Manual - Physician and Professional Services - Evaluation and Management Services (E/M)	Covered, except for Medicare products - See Reimbursement Policy - Telephone Services on Medica.com	Covered for all products per the Administrative policy - Telehealth Services on healthpartners.com Including: E-visits, **scheduled telephone visits** and telehealth services via interactive AV or online video consult	Not covered per Provider Policy and Procedure manual - Ch.11 Medical Services-11-46 - Telephone Calls on bluecrossmn.com
E-Visits: VirtuWell, etc.	99444 - Physician/NP/PA 98969 - Non-Physician	Nothing mentioned in the E/M setion or in the Telemedicine section of manual	Covered for most plans - See Coverage Policy dated July 2011 - Not sure if still valid?	Covered for all products per the Administrative policy - Telehealth Services on healthpartners.com Including: **E-visits**, scheduled telephone visits and telehealth services via interactive AV or online video consult	Covered for all BCBS members (except FEP, Medicare supplements, PMAP and some self-insured groups) per Provider Policy and Procedure manual - Ch. 11 Medical Services -11-22 to 11-26.

Type of Telemedicine	Coding	Reimbursement/Coverage Policy			
		DHS	**Medica**	**HealthPartners**	**BCBS of MN**
Traditional Telemedine: Host Site and Consulting Site	HCPCS code with: >modifier -GT (interactive AV) >modifier -GQ (asynchronous telecommunication) - Q3014 - Originating (host) site	Per MHCP Provider Manual - Several eligible providers are listed including MD, NP, PA, etc. Several authorized originating sites are listed include clinic, hospital and home. Eligible services are also listed. Limitations: 3X per week per recipient	Covered for most plans - Exact same language for MHCP patients as is published in MHCP DHS manual.	Covered for all products per the Administrative policy - Telehealth Services on healthpartners.com Including: E-visits, scheduled telephone visits and **telehealth services via interactive AV** or online video consult	**Interactive AV telehealth** is covered for all BCBS members (except FEP, Medicare supplements, PMAP and some self-insured groups) per Provider Policy and Procedure manual - Ch. 11 Medical Services -11-22 to 11-26.
Psychiatric Consultation to Primary Care: - A consultation initiated by the primary care practitioner/provider to psychiatrist, APRN (certified in psychiatric mental health) or psychologist for an opinion or advice regarding a patient	>Primary Care – 99499 HE AG >Primary Care – 99499 HE AG U4 (non-F2F) >Primary Care 99499 HE AG U7 (by physician extender) >Primary Care 99499 HE AG U4 U7 (non-F2F by physician extender) >Consulting Psychiatrist – 99499 HE AM >Consulting Psychiatrist – 99499 HE AM U4 (non-F2F) >Consulting APRN (certified in psychiatric mental health) – 99499 HE AM >Consulting APRN (certified in psychiatric mental health) – 99499 HE AM U4 (non-F2F) >Consulting psychologist – 99499 HE AM >Consulting psychologist – 99499 HE AM U4 (non-F2F)	Covered for all State Public Programs: DHS and PMAPs	No specific policy found	No specific policy found	No specific policy found

Type of Telemedicine	Coding	Reimbursement/Coverage Policy			
		DHS	Medica	HealthPartners	BCBS of MN
Newly Legislated Telemedicine Benefit Service: Patient is at home or other and clinician provides an online televideo service via a HIPAA compliant mechanism	Use of modifier -GT on appropriate CPT?	Per the MHCP Provider Manaul - Covered? Home is listed as an authorized orginating site. No specific policy relating to televideo consultation services found	No specific policy found	Covered for all products per the Administrative policy - Telehealth Services on healthpartners.com Including: E-visits, scheduled telephone visits and telehealth services via interactive AV or **online video consult**	"**Internet Consultations**" are excluded from coverage along with telephone calls per th Provider Policy and Procedure manual - Ch.11 Medical Services - Televideo Consultations 11-46 to 11-48
Other?					

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH			
Date Received: August 12, 2016	**Log No.:** 084	**Date Closed:**	
Date Sent to AUC Executive Committee: August 15, 2016	**Date Sent to AUC TAG Co-chair(s):**	**TAG Recommendation:** _____ Accept _____ Reject	**Date Decision Sent to Originator:**

REMINDER: After completing sections I and II, submit to the AUC inbox at health.AUC@state.mn.us. The Medical Code TAG Decision Tree form must be completed for medical coding issues and submitted with the SBAR. It is recommended that the Decision Tree form be completed first.

Section I – SBAR Short Title, Date, and Contact information (Person submitting the SBAR and/or Subject Matter Expert). All fields must be completed. Incomplete forms will be returned to the submitter.

SBAR Short title (Required):	Version #:	Date submitted to AUC (Required):
Telehealth place of service (POS)		August 12, 2016

Contact Information for person completing this form (Required):	Organization Information (Required):
Name: Barb Andreasen **Title: Director, Telehealth and Regional Development** **Email address: Barbara.andreasen@allina.com** **Telephone: 612-262-1533**	**Name: Allina Health** **Address: 2925 Chicago Ave, Minneapolis, MN 55407**

SBAR presenter, if different from above:

Name: Susan Lee
Title: Lead Business Analyst, EDI
Email address: Susan.Lee@allina.com
Phone number: 613-262-5690

Please note: The SBAR presenter must be in attendance or available during the meeting(s) in order for the SBAR to be discussed. You will received notification from the TAG co-chair with the meeting date and time when the SBAR will be discussed.

Section II – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation). Each letter must be completed before the SBAR will receive consideration.

SBAR Issue Title:

S	**SITUATION** – There is confusion over the correct POS to bill payers. We are getting different directions from payers and others knowledgeable in telehealth services. Some say the POS should be the patient's location, others say the POS should be the location of the distant provider. Medicare requires that Providers bill with the correct POS of the "Patient location." For commercial payers, HealthPartners and Medica agree that the POS should be the patient location. However, Blue Cross Blue Shield of Minnesota (BCBSM) insists that providers bill with the distant site POS, with an appropriate telehealth modifier. They seem to acknowledge that this is different than Medicare requirements. DHS staff (in 7-12-16 e-mail from Diogo Reis) said in e-mail communication that: "My understanding is that the place of service is the distant site." However, since the Minnesota

	Telehealth Parity Act does not pay the originating site any fee, there may be confusion about the nature of the question from DHS. We are following up with DHS.[1]
B	**BACKGROUND** – Allina previously had a team review and determine the POS that should be billed for telehealth services. This review came at the Telehealth departments request as we began billing for this services. We had several people review the situation and at that time settled on the POS being the location the patient or beneficiary is located (since that is what Medicare required). Here is summary of Medicare POS requirements for telehealth: Claims for telehealth services are submitted to the contractors that process claims …Physician/practicioners submit the appropriate HCPCS procedure code for covered professional telehealth services along with the "GT" Modifier ("via interactive audio and video telecommunications.") [Ch. 12 , section 190.6.1 of Medicare Claims Processing Manual] "The POS code is generally used to reflect the actual setting where the beneficiary receives the face-to-face service." (Ch. 26, Sec 10.6 of Medicare Claims Processing Manual). We took this Medicare guidance and implemented it for all payers (with the understanding that commercial payers could take different position). Now some payers (Blue Cross and possibly DHS), would like to take a different approach.  CAH Telehealth Billing Manual Guidance (exc
A	**ASSESSMENT** – As we began investigations into reimbursement for the established patient primary care visits project, we inquired if payers would reimburse for these E&M visits with the POS 12 (patients home). We received affirmative answers from Medica and HP, but BCBSM informed us that we are using the wrong POS and that it should be where the provider is located. James Lucken Hills and Melissa Lindberg have followed up with their contacts who have reiterated the same position. Here is BC's response:  Telehealth POS 12 feedback from Blue C We reconvened a group to discuss this topic and included government relations who inquired to DHS with the same question. Here is their response:

[1] Traditionally, the POS code is used to determine whether the physician should be paid as a "free standing clinic" (such rates being generally higher for physician since overhead is built in), or "hospital/provider based" (which is generally lower for physician, since the hospital is also able to bill its "facility fee."). Since the Minnesota Telehealth Parity Act does not permit a "facility fee" to be paid to the originating site for Medicaid, the choice of the POS Code likely does not have an impact on Medicaid claims. (Whereas, Medicare pays a small fee to the originating site, in addition to the physician's fee at the distant site).

RE Blue Cross
telehealth reimburser

I was conducting some additional analysis and noticed the 2017 proposed Medicare changes had a section on POS. I copied and pasted that information into a word document which I have attached here. Here is an excerpt of proposed CMS guidance on POS codes for telehealth in the 2017 proposed changes:

> **4. Place of Service (POS) Code for Telehealth Services**
> CMS has received multiple requests from various stakeholders to establish a POS code to identify services furnished via telehealth. These requests have come from other payers, but may also be related to confusion concerning whether to use the POS where the distant site physician is located or the POS where the patient is located.
> …
> Therefore, we are proposing how a POS code for telehealth would be used under the PFS with the expectation that, if such a code is available, it would be used as early as January 1, 2017. We propose that the physicians or practitioners furnishing telehealth services would be required to report the telehealth POS code to indicate that the billed service is furnished as a telehealth service from a distant site. … Our proposed requirement for physicians and practitioners to use the telehealth POS code to report that telehealth services were furnished from a distant site would improve payment accuracy and consistency in telehealth claims submission. Currently, for services furnished via telehealth, we have instructed practitioners to report the POS code that would have been reported had the service been furnished in person. However, some practitioners use the POS where they are located when the service is furnished, while others use the POS corresponding to the patient's location.
>
> **[Source:** 81 FR 46161 (July 15, 2016) <https://www.federalregister.gov/articles/2016/07/15/2016-16097/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions#h-67>].

So, there is possibility that CMS will add a new POS Code (neither location of patient, nor location of distant physician, but rather a new telehealth POS Code to report that telehealth services were furnished from a distant site).

The CMS proposed guidance clearly shows that both approaches for POS are being used currently. We would like to have a single standard POS across all payers.

R

RECOMMENDATION – I would like someone to aide in determining the correct POS for telehealth to bill. Ideally, we would like a single appoach to POS codes across all payers for telehealth services. If a single POS approach is not possible for all payers, then a second-best would be a clear understanding of which payers deviate from a standard default position. It may be helpful to seek guidance from payers and other providers through the Administrative Uniformity Committee.

Section III – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; coding issue addressed or SBAR issue title; whether TAG accepted or rejected recommendation requested in SBAR; explanation or basis for TAG decision and SBAR response will be placed in recommendation grid or companion guide):

Date [SBAR Response Approved by TAG]:

Reviewed by [AUC TAG Name]:

AUC Co-Chair(s):

Discussion/Summary:

Key Findings and Recommendation(s):

Disposition status *(e.g., Minnesota Uniform Companion Guide or Best practice)*:

Decision Summary:

AUC Response:

The findings and recommendations above were also reviewed and _____ by the AUC.

AUC Approval Date:

Medicare Billing Guidance for CAHs and Telehealth

[Note: The following excerpts are intended to serve as a useful starting point only. These contents are currently only as of Dec. 1, 2015, may not represent all available law or guidance on the subject, and should not be relied upon without conducting independent research and verification.]

Medicare Learning Network (MedLearn), "Telehealth Services: Rural Medicine Fact Sheet Series," Dec. 2014, p. 4:

"BILLING AND PAYMENT FOR PROFESSIONAL SERVICES FURNISHED VIA TELEHEALTH

You should submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, "via interactive audio and video telecommunications systems" (for example, 99201 GT)….

You should bill the Medicare Administrative Contractor (MAC) for covered telehealth services. Medicare pays you the appropriate amount under the Medicare Physician Fee Schedule (PFS) for telehealth services. When you are located in a CAH and have reassigned your billing rights to a CAH that has elected the Optional Payment Method, the CAH bills the MAC for telehealth services and the payment amount is 80 percent of the Medicare PFS for telehealth services.

BILLING AND PAYMENT FOR THE ORIGINATING SITE FACILITY FEE

Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS code Q3014. You should bill the MAC for the originating site facility fee, which is a separately billable Part B payment."

Medicare Claims Processing Manual, Ch. 12, Section 190.6 ("Originating Site Facility Fee Payment Methodology")

"The originating site facility fee is a separately billable Part B payment. The contractor pays it outside of other payment methodologies…. For telehealth services furnished from October 1, 2001, through December 31, 2002, the originating site facility fee is the lesser of $20 or the actual charge. For services furnished on or after January 1 of each subsequent year, the originating site facility fee is updated by the Medicare Economic Index….

"The payment amount to the originating site is the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee, except CAHs. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance….

When the originating site is a critical access hospital, make payment separately from the cost-based reimbursement methodology. For CAH's, the payment amount is 80 percent of the originating site facility fee."

To receive the originating facility site fee, the provider submits claims with HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." The type of service for the telehealth originating site facility fee is "9, other items and services." ….

By submitting Q3014 HCPCS code, the originating site authenticates they are located in either a rural HPSA or non-MSA county.

This benefit may be billed on bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, and 85X. Unless otherwise applicable, report the originating site facility fee under revenue code 078X and include HCPCS code "Q3014, telehealth originating site facility fee."

[C]ritical access hospitals bill their intermediary for the originating site facility fee. Telehealth bills originating in inpatient hospitals must be submitted on a 12X TOB using the date of discharge as the line item date of service."

Medicare Claims Processing Manual, Ch. 12, Section 190.6.1 ("Submission of Telehealth Claims for Distant Site Practitioners")

"Claims for telehealth services are submitted to the contractors that process claims for the performing physician/practitioner's service area. Physicians/practitioners submit the appropriate HCPCS procedure code for covered professional telehealth services along with the "GT" modifier ("via interactive audio and video telecommunications system")….

In situations where a CAH has elected payment Method II for CAH outpatients, and the practitioner has reassigned his/her benefits to the CAH, FIs should make payment for telehealth services provided by the physician or practitioner at 80 percent of the MPFS amount for the distant site service.

Medicare Claims Processing Manual, Ch. 26, Section 10.6 ("Carrier instructions for Place of Service codes")

"For purposes of payment under the Medicare Physician Fee Schedule (MPFS), the POS code is generally used to reflect the actual setting where the beneficiary receives the face-to-face service."

Q&A on Noridian's website https://med.noridianmedicare.com/web/jeb/education/event-materials/telehealth-qa

"Bill with the correct place of service (POS) of the patient location and if it is not a valid telehealth location (e.g. home), an Advance Beneficiary Notice of Noncoverage (ABN) would be advisable."

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

To Print a Text-Only Version

Telehealth Services

RURAL HEALTH SERIES

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This publication provides the following information on calendar year (CY) 2016 Medicare telehealth services:

- Originating sites;
- Distant site practitioners;
- Telehealth services;
- Billing and payment for professional services furnished via telehealth;
- Billing and payment for the originating site facility fee;
- Resources; and
- Lists of helpful websites and Regional Office Rural Health Coordinators.

When "you" is used in this publication, we are referring to physicians or practitioners at the distant site.

Medicare pays for a limited number of Part B services furnished by a physician or practitioner to an eligible beneficiary via a telecommunications system. For eligible telehealth services, the use of a telecommunications system substitutes for an in-person encounter.

ORIGINATING SITES

An originating site is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:

- A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract; or
- A county outside of a MSA.

ICN 901705 December 2015

The Health Resources and Services Administration (HRSA) determines HPSAs, and the United States (U.S.) Census Bureau determines MSAs. You can access HRSA's Medicare Telehealth Payment Eligibility Analyzer to determine a potential originating site's eligibility for Medicare telehealth payment at http://datawarehouse.hrsa.gov/telehealthAdvisor/telehealthEligibility.aspx on the HRSA website.

Entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the U.S. Department of Health & Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location.

Each CY, the geographic eligibility of an originating site is established based on the status of the area as of December 31st of the prior CY. Such eligibility continues for the full CY.

The originating sites authorized by law are:

- The offices of physicians or practitioners;
- Hospitals;
- Critical Access Hospitals (CAHs);
- Rural Health Clinics;
- Federally Qualified Health Centers;
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
- Skilled Nursing Facilities (SNFs); and
- Community Mental Health Centers (CMHCs).

Note: Independent Renal Dialysis Facilities are not eligible originating sites.

DISTANT SITE PRACTITIONERS

Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to State law) are:

- Physicians;
- Nurse practitioners (NPs);
- Physician assistants (PAs);
- Nurse-midwives;
- Clinical nurse specialists (CNSs);
- Certified registered nurse anesthetists;

- Clinical psychologists (CPs) and clinical social workers (CSWs). CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838; and
- Registered dietitians or nutrition professionals.

TELEHEALTH SERVICES

As a condition of payment, you must use an interactive audio and video telecommunications system that permits real-time communication between you, at the distant site, and the beneficiary, at the originating site. Asynchronous "store and forward" technology is permitted only in Federal telemedicine demonstration programs in Alaska or Hawaii.

The chart on pages 3–4 provides the CY 2016 list of Medicare telehealth services.

CY 2016 Medicare Telehealth Services

Service	Healthcare Common Procedure Coding System (HCPCS)/CPT Code
Telehealth consultations, emergency department or initial inpatient	HCPCS codes G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	HCPCS codes G0406–G0408
Office or other outpatient visits	CPT codes 99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	CPT codes 99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	CPT codes 99307–99310
Individual and group kidney disease education services	HCPCS codes G0420 and G0421
Individual and group diabetes self-management training 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	HCPCS codes G0108 and G0109
Individual and group health and behavior assessment and intervention	CPT codes 96150–96154
Individual psychotherapy	CPT codes 90832–90834 and 90836–90838
Telehealth Pharmacologic Management	HCPCS code G0459
Psychiatric diagnostic interview examination	CPT codes 90791 and 90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents (effective for services furnished on and after January 1, 2016)	CPT code 90963
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents (effective for services furnished on and after January 1, 2016)	CPT code 90964
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents (effective for services furnished on and after January 1, 2016)	CPT code 90965
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older (effective for services furnished on and after January 1, 2016)	CPT code 90966
Individual and group medical nutrition therapy	HCPCS code G0270 and CPT codes 97802–97804
Neurobehavioral status examination	CPT code 96116
Smoking cessation services	HCPCS codes G0436 and G0437 and CPT codes 99406 and 99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	HCPCS codes G0396 and G0397
Annual alcohol misuse screening, 15 minutes	HCPCS code G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	HCPCS code G0443

CY 2016 Medicare Telehealth Services (cont.)

Service	Healthcare Common Procedure Coding System (HCPCS)/CPT Code
Annual depression screening, 15 minutes	HCPCS code G0444
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	HCPCS code G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	HCPCS code G0446
Face-to-face behavioral counseling for obesity, 15 minutes	HCPCS code G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	CPT code 99495
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	CPT code 99496
Psychoanalysis	CPT codes 90845
Family psychotherapy (without the patient present)	CPT code 90846
Family psychotherapy (conjoint psychotherapy) (with patient present)	CPT code 90847
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	CPT code 99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	CPT code 99355
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service) (effective for services furnished on and after January 1, 2016)	CPT code 99356
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service) (effective for services furnished on and after January 1, 2016)	CPT code 99357
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit	HCPCS code G0438
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit	HCPCS code G0439

For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one “hands on” visit (not telehealth) each month to examine the vascular access site.

BILLING AND PAYMENT FOR PROFESSIONAL SERVICES FURNISHED VIA TELEHEALTH

Submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, “via interactive audio and video telecommunications systems” (for example, 99201 GT). By coding and billing the GT modifier with a covered telehealth procedure code, you are certifying that the beneficiary was present at an eligible originating site when you furnished the telehealth service. By coding and billing the GT modifier with a covered ESRD-related service telehealth code, you are certifying that you furnished one “hands on” visit per month to examine the vascular access site.

For Federal telemedicine demonstration programs in Alaska or Hawaii, submit claims using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GQ if you performed telehealth services "via an asynchronous telecommunications system" (for example, 99201 GQ). By coding and billing the GQ modifier, you are certifying that the asynchronous medical file was collected and transmitted to you at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.

You should bill the Medicare Administrative Contractor (MAC) for covered telehealth services. Medicare pays you the appropriate amount under the Medicare Physician Fee Schedule (PFS) for telehealth services. When you are located in a CAH and reassigned your billing rights to a CAH that elected the Optional Payment Method, the CAH bills the MAC for telehealth services and the payment amount is 80 percent of the Medicare PFS for telehealth services.

BILLING AND PAYMENT FOR THE ORIGINATING SITE FACILITY FEE

Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS code Q3014. Bill the MAC for the originating site facility fee, which is a separately billable Part B payment.

Note: When a CMHC serves as an originating site, the originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services.

RESOURCES

The chart below provides telehealth services resource information.

Telehealth Services Resources

For More Information About…	Resource
Telehealth Services	https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth on the Centers for Medicare & Medicaid Services (CMS) website Chapter 15 of the "Medicare Benefit Policy Manual" (Publication 100-02) on the CMS website Chapter 12 of the "Medicare Claims Processing Manual" (Publication 100-04) on the CMS website
Health Professional Shortage Areas	Medicare Learning Network® (MLN) publication titled "Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs" on the CMS website
All Available MLN Products	"MLN Catalog" on the CMS website
Provider-Specific Medicare Information	MLN publication titled "MLN Guided Pathways: Provider Specific Medicare Resources" on the CMS website
Medicare Information for Beneficiaries	https://www.medicare.gov on the CMS website

HELPFUL WEBSITES

American Hospital Association Rural Health Care
http://www.aha.org/advocacy-issues/rural

Critical Access Hospitals Center
https://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html

Disproportionate Share Hospitals
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

Federally Qualified Health Centers Center
https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

Health Resources and Services Administration
http://www.hrsa.gov

Hospital Center
https://www.cms.gov/Center/Provider-Type/Hospital-Center.html

Medicare Learning Network®
http://go.cms.gov/MLNGenInfo

National Association of Community Health Centers
http://www.nachc.org

National Association of Rural Health Clinics
http://narhc.org

National Rural Health Association
http://www.ruralhealthweb.org

Rural Health Clinics Center
https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Rural Health Information Hub
https://www.ruralhealthinfo.org

Swing Bed Providers
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html

Telehealth
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth

U.S. Census Bureau
http://www.census.gov

REGIONAL OFFICE RURAL HEALTH COORDINATORS

To find contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues, refer to https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf on the CMS website.

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