

used for other Medicare services payable under the physician fee schedule.

Medicare co-payments and deductibles would apply for medical nutritional therapy services. We are proposing to pay for this service under the physician fee schedule using the following codes:

CPT 97802—Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.

CPT 97803—reassessments and intervention, individual, face-to-face with the patient, each 15 minutes.

CPT 97804—Group, 2 or more individuals, each 30 minutes.

Since payment for MNT will be included in our payment for facility services, separate payment will not be made for hospital inpatients or skilled nursing facility patients. Section 105(c) of BIPA amends section 1833(a)(1) to add subparagraph (T), requiring Medicare payment to equal 80 percent of the of the lesser of the actual charge for the service or 85 percent of the amount determined under the physician fee schedule. Thus, we will make payment in the hospital outpatient department, Federally Qualified Health Centers and Rural Health Clinics at the lesser of 80 percent of the actual charge or 85 percent of the physician fee schedule amount. The RVUs shown above do not reflect this 85 percent adjustment. To determine payment, the RVUs shown above will need to be multiplied by the physician fee schedule conversion factor and 0.85. We expect to provide the Medicare carriers with a payment file that includes this 85 percent adjustment. That is, we expect to determine the payment amount using the RVUs shown and apply the 85 percent adjustment to the product of the geographically adjusted RVUs and conversion factor. The Medicare carriers will not need to make any additional adjustment to the payments we provide.

F. Telehealth Services

1. Background

a. History. Before January 1, 1999, payment for services delivered via a telecommunications system was limited to services that do not require a face-to-face, “hands-on” encounter under the traditional delivery of medical care. Examples of these services include interpretation of an x-ray, electrocardiogram and electroencephalogram tracings, and cardiac pacemaker analysis.

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 (HPSA) as defined by section 332(a)(1)(A) of the Public Health Services Act. Additionally, a Medicare practitioner was required to be with the patient at the time of a teleconsultation.

The BBA specified that payment for a teleconsultation had to be shared between the consulting physician or practitioner and the referring physician or practitioner and could not exceed the fee schedule payment which would have been made to the consultant for the service provided. The BBA prohibited payment for any line charges or facility fees associated with the teleconsultation and clarified that the beneficiary may not be billed for these charges or fees.

These provisions became effective January 1, 1999. The November 2, 1998 final rule on “Revisions to Payment Policies Under the Physicians Fee Schedule for Calendar Year 1999” (63 FR 58879) implemented these provisions.

b. Legislative Summary. In section 223 of the BIPA, the Congress provided for a “Revision of Medicare Reimbursement for Telehealth Services” and specified a “sunset” date for the current statutory teleconsultation provisions. The current teleconsultation provisions contained in section 4206(a) and (b) of the BBA and implemented in §§ 410.78 and 414.65 apply only to teleconsultations provided on or after January 1, 1999 and before October 1, 2001.

Beginning October 1, 2001, the BIPA amends section 1834 of the Act to provide for a new subsection (m) “Payment for Telehealth Services.” This amendment provides for an expansion of Medicare payment for telehealth services. A summary of the expansion appears below.

The BIPA specifies that we pay for telehealth services that are furnished via a telecommunications system by a physician (as defined in section 1861(r) of the Act) or a practitioner (described in section 1842(b)(18)(C) of the Act). Telehealth services may be provided only to an eligible telehealth individual enrolled under Medicare, notwithstanding the fact that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary.

The BIPA defines Medicare telehealth services as professional consultations, office or other outpatient visits, and office psychiatry services identified as of July 1, 2000, by CPT codes 99241 through 99275; 99201 through 99215, 90804 through 90809 and 90862 (and as we may subsequently modify) and any additional service we specify.

The statute requires us to establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes) as appropriate, to the services specified above, for authorized payment under Medicare.

Section 1834(m)(4)(B) of the Act, as added by the BIPA, specifies that an eligible telehealth individual means an individual enrolled under Part B who receives a telehealth service furnished at an originating site. Originating sites are defined only as specified medical facilities located in specific geographic areas. Section 1834(m)(4)(C) of the Act, as added by the BIPA, limits originating sites to the following types of facilities:

- The office of a physician or practitioner.
- A critical access hospital (as defined in section 1861(mm)(1) of the Act).
- A rural health clinic (as defined in section 1861(aa)(s) of the Act).
- A Federally qualified health center (as defined in section 1861(aa)(4) of the Act).
- A hospital (as defined in section 1861(e) of the Act).

The BIPA specifies that the originating site must be located in one of the following geographic areas:

- In an area that is designated as a rural health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act.
- In a county that is not included in a Metropolitan Statistical Area.
- From 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.

The BIPA relaxes some of the conditions for payment imposed by the BBA. Section 1834(m)(2)(C) of the Act, as added by the BIPA, specifies that a telepresenter is not required and specifically states that nothing in section 1834(m)(2)(C) of the Act shall be construed as requiring an eligible telehealth beneficiary to be presented by a physician or practitioner at the originating site for the furnishing of a service via a telecommunications system, unless it is medically necessary (as determined by the physician or practitioner at the distant site).

Additionally, section 1834(m)(1) of the Act, as added by the BIPA, specifies that, for purposes of defining a telecommunications system, in the case of any Federal telemedicine demonstration program conducted in Alaska or Hawaii, the term “telecommunications system” includes store and forward technologies that

provide for the asynchronous transmission of health care information in single or multimedia formats.

Section 1834(m)(2) of the Act, as added by the BIPA, states that we pay a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth beneficiary an amount equal to the amount that the physician or practitioner would have been paid under Medicare had the service been furnished without the use of a telecommunications system.

This section also provides for a facility fee payment to the originating site. It specifies that for the period beginning October 1, 2001 through December 31, 2002, the originating site facility fee is equal to \$20. For each subsequent year, the facility fee for the preceding year is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act.

The BIPA amended section 1833(a)(1) of the Act by adding subparagraph (U), specifying that with respect to the originating site facility fees, the amount paid is 80 percent of the lesser of the actual charge or the amounts specified in new section 1834(m)(2) of the Act.

Section 1834(m)(3) of the Act requires that the provisions of sections 1848(g) and 1842(b)(18)(A) and (B) of the Act apply to physicians and practitioners. The provisions of section 1842(b)(18) of the Act apply to originating sites receiving a facility payment as the provisions apply to practitioners under section 1834(m) of the Act.

Section 1848(g) of the Act provides a limitation of charges to beneficiaries and provides sanctions if a physician, supplier, or other person knowingly and willfully bills or collects for services in violation of the limitation. It also provides for sanctions if a physician, supplier, or other person fails—(1) to timely correct excess charges by reducing the actual charge billed for the service to an amount that does not exceed the limiting charge for the service, or (2) to timely refund excess collections. In addition, it requires that physicians and suppliers submit claims for services they furnished to a beneficiary to a carrier on behalf of the beneficiary using a standard Medicare claim form. The statute imposes a penalty for failure to submit the claim. In addition, section 1848(g) of the Act prohibits imposing any charge relating to completing and submitting the claim. Section 1842(b)(18) of the Act provides that services furnished by a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, anesthesiologist's assistant, certified nurse-midwife,

clinical social worker, or clinical psychologist for which payment may be made on a reasonable charge or fee schedule basis may be made only on an assignment-related basis. It also limits the beneficiary's liability to any applicable deductible and coinsurance amounts. It further provides for sanctions against a practitioner who knowingly and willfully bills (or collects an amount) in violation of the limitation.

c. Implementation. Section 223 of the BIPA limits the application of the existing telehealth provision to services furnished before October 1, 2001 and mandates that the expanded benefit be effective for services furnished on or after October 1, 2001. Therefore, this benefit expansion is being implemented via program memorandum. The program memorandum is effective October 1, 2001 when the telehealth benefit supercedes the teleconsultation benefit authorized by section 4206 of the BBA and existing regulations at § 410.78 and § 414.65. Any regulatory changes resulting from this rulemaking process will be effective January 1, 2002.

d. Proposed Policies. This rule proposes to establish policies for implementing the provisions of section 1834(m) of the Act, as added by the BIPA, that change Medicare payment for telehealth services.

(i) Scope of telehealth benefit. Section 1834(m)(4)(B) of the Act, as added by the BIPA, defines an eligible telehealth individual as a Medicare beneficiary who receives a telehealth service furnished at an originating site. As discussed earlier, originating sites are limited to certain facilities within specifically identified geographic areas.

We would revise § 410.78 to specify that Medicare beneficiaries are eligible for telehealth services only if they receive services from an originating site located in either a rural HPSA as defined by section 332(a)(1)(A) of the Public Health Services Act or in a county outside of a MSA as defined by section 1886(d)(2)(D) of the Act. Additionally, we would provide for an exception if an entity participates in a Federal telemedicine demonstration project that has been approved by, or receives funding from, us as of December 31, 2000. That entity would not be required to be in a rural HPSA or non-MSA as described above.

We would also specify that, providing the geographic criteria are met, the following sites qualify as originating sites under this provision:

- The office of a physician or practitioner.
- A hospital as defined in section 1861(e) of the Act.

- A critical access hospital as defined in section 1861(mm)(1).
- A rural health clinic as defined in section 1861(aa)(2) of the Act.
- A Federally qualified health center as defined in section 1861(aa)(4) of the Act.

Covered Services. Section 1834(m)(4)(F) of the Act, as added by the BIPA, defines telehealth services as professional consultations, office and other outpatient visits, individual psychotherapy, pharmacologic management and any additional service we specify. Additionally, this provision identifies covered services by HCPCS codes identified as of July 1, 2000. We propose to revise § 410.78 to implement this coverage expansion. The services and corresponding CPT codes are listed below:

- Consultations (codes 99241 through 99275).
- Office and other outpatient visits (codes 99201 through 99215).
- Individual Psychotherapy (codes 90804 through 90809).
- Pharmacologic management (code 90862).

The BIPA provision is effective for services beginning on October 1, 2001. Payment for the statutorily specified codes, as listed above, will be implemented beginning with that date. We propose to make any additions or deletions to the services defined as telehealth effective on a January 1st basis. We plan to use the annual physician fee schedule proposed rule published in the summer and the final rule (published by November 1) each year as the vehicle to make these changes. Since the statutory provision will be implemented on October 1, 2001, and there is limited published data on telehealth in clinical settings, we will not make any recommendations on additional services until we have had time to ensure we have a process for redefining covered services in place.

We are soliciting suggestions and comments from the public regarding the guidelines that we should use to make additions or deletions of services. We also solicit suggestions and comments about specific services that may be appropriate to be covered under the Medicare telehealth benefit. Once we complete our review of these suggestions and comments, we will propose a more detailed approach as to how we would make modifications to the existing telehealth benefit.

(ii) Conditions of Payment: *Technology.* The Congress defines the term "telecommunications system" with respect to demonstration projects conducted in Alaska or Hawaii; however, the BIPA does not define a

telecommunications system in any other case. In a non-telehealth setting, Medicare pays for these codes only if there is a face-to-face encounter between the patient and attending physician or practitioner. We believe that the patient's presence and use of an interactive audio and video telecommunications system permitting the distant site practitioner to interact with the patient provides a reasonable substitute for a face-to-face encounter.

Limited exception to the interactive telecommunications requirement. For purposes of defining a telecommunications system, section 1834(m)(1) of the Act includes the use of store and forward technology in very limited circumstances. This provision specifies that, in the case of a Federal telemedicine demonstration program conducted in Alaska or Hawaii, Medicare payment is permitted when asynchronous, store and forward technologies, in single or multimedia formats is used to deliver the service.

Store and forward technology substitutes for an interactive, patient-present encounter in these limited circumstances. The patient is not present or available to interact with the distant site physician or practitioner in real-time.

We believe that when store and forward technologies are used to substitute for an interactive patient encounter, the technology must permit the distant site practitioner adequate medical information for recommending or confirming a diagnosis or treatment plan. A patient's medical information may typically include various combinations of the following items—video clips, still images, x-rays, magnetic resonance images, electrocardiogram and electroencephalogram tracings, tissue samples, laboratory results, and audio clips of heart or lungs.

We propose to specify at § 410.78 that, except for the statutory provision noted above, an interactive telecommunications system must be used and that the medical examination of the patient is at the control of the physician or practitioner at the distant site. We would define interactive telecommunications system as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and physician or practitioner at the distant site. We would also specify that telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

Additionally, we would provide an exception to the interactive requirements where the patient must be present for a Federal telemedicine demonstration program conducted in Alaska or Hawaii. We would specify that for Federal telemedicine demonstration programs conducted in Alaska or Hawaii, Medicare payment is permitted for telehealth when asynchronous store and forward technologies, in single or multimedia formats, are used as a substitute for an interactive telecommunications system. Additionally, we would specify that the physician or practitioner at the distant site must be affiliated with the demonstration program.

This exception would be permitted for Federal telemedicine demonstration projects conducted in Alaska or Hawaii only. Interactive telecommunications system with the real-time presence of the patient is required as a condition of payment in all other circumstances.

We would define asynchronous, store and forward technologies, as the transmission of the patient's medical information from an originating site to the physician or practitioner at the distant site. The physician or practitioner at the distant site can review the medical case without the patient being present. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patient's medical condition and adequate for rendering or confirming a diagnosis or treatment plan. Dermatological photographs, for example, a photograph of a skin lesion may be considered to meet the requirement of a single media format under this provision.

Additionally, we would define the originating site as the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous, store and forward telecommunications technologies, an originating site is a Federal telemedicine demonstration program conducted in Alaska or Hawaii.

Telepresenter. As mentioned earlier, the BIPA changed the telepresenter requirements. In accordance with section 1834(m)(2)(C) of the Act, a telepresenter is not required to be present. Therefore, we would not require a telepresenter as a condition of Medicare payment.

Practitioners eligible to receive payment for Medicare Telehealth Services. Section 1834(m)(1) of the Act

requires that Medicare make payments for telehealth services furnished via a telecommunications system by a physician or a practitioner (described in section 1842(b)(18)(C) of the Act). Non-physician practitioners described in this section of the Act include nurse practitioners, physician assistants, clinical nurse specialists, certified nurse midwives, clinical psychologists, clinical social workers, and certified registered nurse anesthetists or anesthesiologists' assistants. Section 1834(m)(2) of the Act specifies that the payment amount to the physician or practitioner at the distant site who furnishes a telehealth service be equal to the amount that the physician or practitioner would have been paid under Medicare had the service been furnished without the use of a telecommunications system.

As discussed earlier in this document, covered telehealth services include office visits (codes 99201 through 99215), consultation (codes 99241 through 99275), individual psychotherapy (codes 90804 through 90809), and pharmacologic management (code 90862). If a physician, clinical nurse specialist, nurse practitioner, physician assistant, nurse midwife, clinical psychologist, or clinical social worker is licensed under State law to provide a service listed above, then these practitioners may bill for and receive payment for this service when delivered via a telecommunications system.

Clinical psychologists and clinical social workers cannot bill or receive payment for psychotherapy involving evaluation and management services under Medicare when the service is delivered face-to-face (that is, without the use of a telecommunications system). Therefore, clinical psychologists and clinical social workers cannot receive payment for these services under the telehealth benefit.

Certified registered nurse anesthetists and anesthesiologists' assistants are not eligible. Certified registered nurse anesthetists and anesthesiologists' assistants would not be permitted to bill for and receive payment for a telehealth service under this provision. Section 1861(bb) of the Act defines services provided by these practitioners as anesthesia services and related care only. Under the Medicare program, these practitioners do not receive payment for office visits, consultation, individual psychotherapy, or pharmacologic management when these services are furnished without the use of a telecommunications system. Section 1834(m)(2) of the Act specifies that the

payment amount made to the distant site physician or practitioner must be equal to what would have been paid for the service without the use of a telecommunications system. Therefore, certified registered nurse anesthetists and anesthesiologists' assistants would not receive payment for telehealth services.

Proposed regulatory provisions. Based on the law, we would state at § 410.78 that, as a condition of Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under State law. When the physician or practitioner at the distant site is licensed under State law to provide a covered telehealth service (that is, professional consultations, office and other outpatient visits, individual psychotherapy, and pharmacologic management), then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

We would specify that the physician or practitioner at the distant site may be any of the following (provided that the physician or practitioner is licensed to bill for the service being furnished via a telecommunications system):

- A physician as described in § 410.20.
- A physician assistant as defined in § 410.74.
- A nurse practitioner as defined in § 410.75.
- A clinical nurse specialist as described in § 410.76.
- A nurse midwife as defined in § 410.77.
- A clinical psychologist as described in § 410.71.
- A clinical social worker as defined in § 410.73.

However, we would further specify that a clinical psychologist and clinical social worker may bill for individual psychotherapy furnished via a telecommunications system, but may not seek payment for medical evaluation and management services.

Documentation. Documentation requirements as specified in our most recent documentation guidelines are applicable to services delivered via a telecommunications system. At this time, we will not require additional documentation under this provision beyond what is already required for medical services delivered without the use of a telecommunications system. Medicare documentation guidelines are available from our web site. You may access our documentation guidelines by using the following directions:

1. Go to the CMS Homepage (<http://www.cms.gov>).

2. Click on "Medicare" (Top left hand column).
3. Click on "Professional/Technical Information"
4. Click on "Documentation Guidelines for Evaluation and Management Services:"
5. You may choose the 1995 version or the 1997 version whichever best fits your needs.

(iii) Payment provisions. *Professional Services: General*—Section 1834(m)(2)(A) of the Act, specifies that the payment amount for the professional service is equal to the amount that would have been paid without the use of a telecommunications system. Medicare payment for physicians' services is generally based, under section 1848 of the Act, on the resource-based physician fee schedule. Payment to other health care practitioners listed earlier, authorized under section 1833 of the Act, is based on a percentage of the physician fee schedule payment amount. Therefore, we would pay for office or other outpatient visits, consultation, individual psychotherapy, and pharmacologic management services furnished by physicians at 80 percent of the lower of the actual charge or the fee schedule amount for physicians' services. We would also pay for services furnished by other practitioners at 80 percent of the lower of the actual charge or that practitioner's respective percentage of the physician fee schedule (for example, the fee schedule amount for clinical psychologists would be 100 percent of the physician fee schedule; for clinical social workers, the payment would be made at 75 percent of the clinical psychologist fee schedule; for certified nurse midwives, the payment would be made at 65 percent of the physicians fee schedule; and for all other eligible health care practitioners, payment would be made at 85 percent of the physician fee schedule). Assuming the beneficiary has met his or her Part B deductible, the beneficiary would be responsible for 20 percent of the appropriate payment amount.

Payment for Telepresenter. Section 1834(m)(2) of the Act, provides for a professional fee for the physician or practitioner at the distant site (equal to the applicable Part B fee schedule amount) and a \$20 facility fee for the originating site. Telepresenters are not required, unless one is deemed medically necessary by the physician or practitioner at the distant site. BIPA does not address the issue of payment for the telepresenter. The Office of the Inspector General has advised us that permitting the physician or practitioner

at the distant site to pay the telepresenter creates a significant risk under the anti-kickback statute and may also violate many State fee-splitting laws. Therefore, we would propose in § 414.65 that payments made to the distant site physician or practitioner for professional fees, including deductible and coinsurance (for the professional service), are not to be shared with the referring practitioner or telepresenter.

However, the telepresenter could bill and receive payment for services that are not telehealth services that a telepresenter would otherwise be allowed to provide under the Medicare statute, including services furnished on the same day as the telehealth service.

Facility Fee for the Originating Site. The BBA prohibited any payment for line charges or facility fees associated with a professional consultation via a telecommunications system. Section 1834(m)(2)(B) of the Act, as added by the BIPA, provides for a facility fee payment to the originating site, specifying that the amount of payment is 80 percent of the lesser of the actual charge or a facility fee of \$20.00. The BIPA further specifies that, beginning January 1, 2003, the originating facility fee be increased annually by the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act. Additionally, we clarify that the Geographic Practice Cost Index (GPCI) would not apply to the facility fee for the originating site. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the physician's fee schedule. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance. We would revise § 414.65 to provide for payment of a facility fee to the originating site.

Coding. For office and other outpatient visits, consultation, individual psychotherapy, and pharmacologic management delivered via a telecommunications system, we would use modifiers in conjunction with existing CPT codes to indicate the use of a telecommunications system in delivering the service.

A new HCPCS code for the facility fee for the originating site will be used to identify this fee. Since this is a new occasion of payment under Medicare, a separate and distinct code for the facility fee is necessary for contractors to make the appropriate payment.

G. Indian Health Service

The Indian health care system provides primary health care to many American Indian and Alaska Native Medicare beneficiaries. This system consists of programs operated by a