Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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REFER TO CHANGE REQUESTS 1650 & 1827

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
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CLARIFICATION/MANUALIZATION--*EFFECTIVE DATE: Not Applicable*
IMPLEMENTATION DATE: Not Applicable

This instruction manualizes intermediary claims processing instructions contained in Program Memoranda AB-02-052 (CR 1650) and AB-02-053 (CR 1827) regarding the processing of telehealth services.

Section 3660.2, Telehealth Services is added to provide claims processing instructions and coding requirements for covered telehealth services.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CHAPTER VII
BILL REVIEW

Section

Cost Reimbursement Providers

NOTE: A patient's residence is the Place where he makes his home and dwells permanently or for an extended period of time. A SNF is an institution which meets §1861(j)(1) of the Act.

(b) SNF to a hospital to a SNF	(b) Condition met if pickup point was in the service area of the destination as shown in your locality guide. Condition met where the pickup point is outside the service area of the destination if the destination institution was the nearest one with the appropriate facilities. Refer to supervisor for determination.
(c) Hospital to hospital or SNF to SNF.	(c) Condition met if the discharging institution was not an appropriate facility and the admitting facility was one with appropriate facilities.
(d) From a hospital or SNF to a patient's residence.	(d) Condition met if patient's residence is within the institution's service area as shown in your locality guide. Condition met where the patient's residence is outside the institution's service area if the institution was the nearest one with appropriate facilities. Refer to supervisor for determination.

NOTE: Ambulance service to a physician's office or a physician-directed clinic is not covered. (See §3114C.5 where a stop is made at a physician's office enroute to a hospital.)

K. Partial Payment.--Partial reimbursement may be made for otherwise covered ambulance service which exceed the criteria in 4 above. Base payment upon the amount the nearest appropriate facility. However, when the beneficiary was transported from a distant hospital or a SNF to his residence, base payment upon the amount that would have been payable had the beneficiary been transported to his residence from the nearest institution with appropriate facilities.

I. Zip Code File on the CMS Mainframe Telecommunication System (CMSMTS).--Every 2 months, CMS obtains an updated listing of zip codes from the U.S. Postal Service (USPS). On the basis of the updated USPS file, CMS updates the Medicare zip code file and makes it available to contractors.

Beginning in April 2002, and every calendar quarter thereafter, CMS will upload an updated zip code file on the CMSMTS (formerly the Connect: Direct or the Network Data Mover) and furnish notice of its availability via e-mail.

Approximately 6 weeks prior to the beginning of each calendar quarter (i.e., approximately 6 weeks prior to January 1, April 1, July 1, and October 1), an e-mail will be sent out notifying all carriers, intermediaries, and systems maintainers of the availability of the updated file. The updated file will be available in early November for the January 1 release, early February for the April 1 release, early May for the July 1 release, and early August for the October 1 release.

The name of the file will be in the following format:

MU00.AAA2390.ZIP.LOCALITY.VCCYYQ. Only the last 5 positions of the name (i.e., "CCYYQ") will vary (for century, year, and quarter). So, for example, the name of the file updated for April 2002 is MU00.AAA2390.ZIP.LOCALITY.V20022. The release number for this file is 20022, release 2 for the year 2002.

When the updated file is loaded to the CMSMTS, it will overlay the previous zip code file.

NOTE: Even the most recently updated zip code file will not contain zip codes established by the USPS after CMS compiled the file. Therefore, for zip codes reported on claims that are not on the most recent zip code file, follow the instructions in Program Memorandum AB-00-88.

Once you receive e-mail giving notice of the availability of an updated zip code file, go to the CMSMTS and search for the file. Confirm that the release number (the last 5 digits) corresponds to the upcoming calendar quarter. If the release number (the last 5 digits) does not correspond to the upcoming calendar quarter, notify Nicole Atkins at 410-786-8278.

Once you have confirmed that the zip code file on the CMSMTS corresponds to the next calendar quarter, download the file and incorporate the file into your testing regime for the upcoming model release.

3660.2 TELEHEALTH SERVICES

See Chapter V §3497 for coverage and payment rules pertaining to Medicare telehealth services.

Submission of telehealth claims from originating site – The term originating site means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. These sites can be hospitals (inpatient, outpatient, critical access hospitals), Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). For asynchronous, store and forward telecommunications technologies an originating site for Medicare payment purposes can only be a Federal telemedicine demonstration program conducted in Alaska or Hawaii.

The originating site facility fee is a Part B payment. Pay the originating site facility fee outside of current fee schedule or other payment methodologies (e.g., payment must be made in addition to the DRG, outpatient prospective payment system.) For consultation, office or other outpatient visit, psychotherapy and pharmacologic management services delivered via a telecommunications system furnished from October 1, 2001, through December 31, 2002; the originating site fee is the lesser of $20 or the actual charge. The facility site fee will be updated yearly based upon the Medicare economic index and will be announced in an annual PM. These fees are subject to post payment verification.

To receive the originating facility site fee, submit claims with HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." By submitting "Q3014" HCPCS code, the originating site authenticates they are located in either a rural or non-MSA county.

This benefit may be billed on bill types 13x, 71x, 73x, and 85x. The originating site can be located in a number of revenue centers within a facility, such as an emergency room (450), operating room (360), or clinic (510). Report this service under the revenue center where the service was performed and include HCPCS code "Q3014, telehealth originating site facility fee."

Hospitals and critical access hospitals bill their intermediary for the originating site facility fee. Telehealth bills originating in inpatient hospitals must be submitted on an 13x (outpatient) TOB using the date of discharge as the line item date of service. Independent and provider-based RHCs

and FQHCs bill the appropriate intermediary using the RHC or FQHC bill type and billing number. HCPCS code "Q3014, is the only non-RHC/FQHC service that is billed using the clinic/center bill type and provider number. For all other non-RHC/FQHC service, provider based RHCs and FQHCs must bill using the provider's bill type and billing number. Independent RHCs and FQHCs must bill the carrier for all other non-RHC/FQHC services. If an RHC/FQHC visit occurs on the same day as a telehealth service, the RHC/FQHC serving as an originating site must bill for HCPCS code "Q3014 telehealth originating site facility fee on a separate revenue line from the RHC/FQHC visit.

The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.

3660.4 All-Inclusive Rate Providers.--

A. Providers Using All-Inclusive Rates for Inpatient Part A Charges.--Providers have the option with your approval to bill a flat fee charge incurred on either a daily basis or total stay basis for services furnished. This is an "All Inclusive Rate." These charges may cover room and board, including ancillary services, or room and board only. These instructions explain the essential data entries that must be made on the Form HCFA-l450 by providers that use all-inclusive rates as charges. All-inclusive rate providers are identified by one of the following charge structures:

- o One total all-inclusive charge rate for both accommodations and ancillary services, including the cost of blood in the rate;
- o One total all-inclusive charge rate for both accommodations and ancillary services, not including the cost of blood in the rate;
- o One all-inclusive charge rate for accommodations and another for ancillary services, including the cost of blood in the all-inclusive rate; or
- o One all-inclusive charge rate for accommodations and another for ancillary services, not including the cost of blood in the all-inclusive rate.

Providers follow these special instructions for completing FLs 42-48 of the billing form.

1. Accommodations.--

Revenue Codes - Codes which identify the accommodations furnished, ancillary services provided or billing calculation are entered in FL 42. The code indicates whether the rate includes charges for ancillary services or only room and board.

If the patient was furnished more than one type of accommodation, the lines for each type of accommodation are completed. This is necessary whether or not the provider charges an all-inclusive rate according to accommodations.

Where the all-inclusive rate varies with the type of accommodation, FL 84 (Remarks) is annotated for a five-or-more bed accommodation showing the reason for the accommodation.

Unit of Service - A quantitative measure for services furnished, by revenue category, to or for the patient which includes items such as the number of accommodation days, pints of blood, or renal dialysis treatments, is entered in FL 46.

Total Charges - The total charges pertaining to the related revenue code for the current billing period is entered in FL 47.

Noncovered Charges - The total non-covered charges pertaining to the related revenue code for the current billing period is entered in FL 48.