CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10282	**Date: August 7, 2020**
	Change Request 11870

SUBJECT: Telehealth Expansion Benefit Enhancement under the Pennsylvania Rural Health Model (PARHM) - Implementation

I. SUMMARY OF CHANGES: As part of Pennsylvania Rural Health Model (PARHM), participating rural hospitals must submit rural health transformation strategies called "Transformation Plans." These plans detail what healthcare delivery, coordination, and operations improvements the hospital plans to implement to reach the population health goals and financial benchmarks of the Model. Many hospitals have identified telehealth strategies in their Transformation Plans. The Model defines rural eligibility differently than the Metropolitan Statistical Area methodology, and therefore only some participating rural hospitals in the Model are currently able to utilize telehealth services. This Change Request seeks to expand the allowable telehealth services for Model participant hospitals. This Change Request is needed to address this inequality and without it, some hospitals may fail at meeting healthcare transformation goals set by the Model.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Demonstrations

Attachment - Demonstrations

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I. GENERAL INFORMATION

A. Background: The Pennsylvania Rural Health Model (PARHM) provides rural acute care hospitals and Critical Access Hospitals (CAH) the opportunity to participate in hospital global budget payments for all inpatient and outpatient hospital services and CAH swing bed services. CMS reimburses participant rural hospitals according to an annual global budget, which is provided by the Commonwealth of Pennsylvania. CMS reimburses the participant rural hospitals on a biweekly basis based on 1/26 of their global budget through the applicable MACs. Pennsylvania provides CMS the annual global budgets for participant hospitals prior to the performance year (performance year is based on the calendar year). CMS will provide information to the MACs of the participant rural hospitals and the Part A and Part B global budget payment amounts for hospital inpatient and outpatient services. Participant rural hospitals also submit claims to CMS, but zero claims payments are made. This model is effective for claims with through or discharges dates on or after January 1, 2018. Beneficiaries and hospitals will be able to participate in other models, under the requirements of those models. Beneficiaries enrolled in a Medicare Advantage plan are excluded from this model.

As part of PARHM, participating rural hospitals must submit rural health transformation strategies called "Transformation Plans." These plans detail what healthcare delivery, coordination, and operations improvements the hospital plans to implement to reach the population health goals and financial benchmarks of the Model. Many hospitals have identified telehealth strategies in their Transformation Plans. The Model defines rural eligibility differently than the Metropolitan Statistical Area methodology, and therefore only some participating rural hospitals in the Model are currently able to utilize telehealth services. This CR provides instruction to Medicare payment contractors to implement a new Telehealth Benefit Enhancement. This CR is needed to address this inequality and without it, some hospitals may fail at meeting healthcare transformation goals set by the Model.

CMS is making available, to qualified PARHM participants, a waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site in order to be eligible to receive telehealth services. This benefit enhancement allows payment of claims for telehealth services delivered by PARHM participants and Preferred Providers to beneficiaries in specified facilities or at their residence regardless of the geographic location of the beneficiary. An interactive telecommunications system is required as a condition of payment; however, CMS is allowing the use of asynchronous telehealth to deliver dermatology and ophthalmology services.

*At-Home Synchronous Telehealth Services***.**

G9481: Remote E/M for a new patient (10 mins.) for CMMI demonstrations only

G9482: Remote E/M for a new patient (20 mins.) for CMMI demonstrations only

G9483: Remote E/M for a new patient (30 mins.) for CMMI demonstrations only

G9484: Remote E/M for a new patient (45 mins.) for CMMI demonstrations only

G9485: Remove E/M for a new patient (60 mins.) for CMMI demonstrations only

G9486: Remote E/M for an established patient (10 mins.) for CMMI demonstrations only

G9487: Remote E/M fir an established patient (15 mins.) for CMMI demonstrations only

G9488: Remote E/M for an established patient (25 mins.) for CMMI demonstrations only

G9489: Remote E/M for an established patient (40 mins.) for CMMI demonstrations only

G0438: Annual wellness visit; first visit

G0439: Annual wellness visit; subsequent visit(s)

Asynchronous defined. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images such as photos) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time or live interaction. 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 patients' condition and adequate for rendering or confirming a diagnosis and or treatment plan.

Payment will be permitted for telemedicine when asynchronous telehealth in single or multimedia formats, is used as a substitute for an interactive telecommunications system for dermatology and ophthalmology services. Distant site practitioners will bill for these services using CMMI Model-only codes listed below and the distant site practitioner must be a PARHM participant or Preferred Provider.

Asynchronous Telecommunication Services.

G9868: Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation (15 minutes)

G9869: Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation (20 minutes)

G9870: Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation (25 minutes)

B. Policy: Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) authorizes the Center for Medicare & Medicaid Innovation to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and Children's Health Insurance Program spending while maintaining or improving the quality of beneficiaries' care.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11870.1	Effective January 1, 2021, contractors shall prepare their systems to process Pennsylvania Rural Health Model (PARHM) claims with dates of service January 1, 2021, and later.					X			X	JL A/B MAC, RRB-SMAC
11870.2	The contractor shall use demonstration code 98 to identify PARHM claims.									HIGLAS, JL A/B MAC, RRB-SMAC
11870.3	The contractor shall process claims and append demo code 98 as PARHM claims when the claim includes: • An aligned provider; • An aligned beneficiary (beneficiary is a Pennsylvania resident); and • A V4 modifier is located at the detail line level; • The benefit enhancement is selected with the Healthcare Common Procedure Coding System (HCPCS) Codes G9481 – G9489, G0438-G0439, or G9868-G9870									JL A/B MAC, RRB-SMAC
11870.3.1	The contractor shall identify PARHM claims at the detail line level when a V4 modifier is associated with this benefit enhancement.									JL A/B MAC, RRB-SMAC
11870.3.2	The contractor shall create a System Control Facility (SCF) code that will add demo code 98 to the claim when the participating National Provider Identifier (NPI), date parameter, procedure code, and modifier (V4) on the detail line identify the service is part of the PARHM demo.									JL A/B MAC, RRB-SMAC
11870.4	The contractor shall ensure that the provider appending the V4 modifier on the claim is on the list of participating providers, prior to appending the demo code.									JL A/B MAC, RRB-SMAC
11870.4.1	The contractor shall deny PARHM claims when there is no aligned provider on the claim and the V4 modifier is appended. The contractor shall use the following messages:									JL A/B MAC, RRB-SMAC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Claims Adjustment Reason Code (CARC): 132 - “Prearranged demonstration project adjustment.” • Remittance Advice Remark Code (RARC): N83 - (No appeal rights. Adjudicative decision based on the provisions of a demonstration project.) • Group Code: CO (Contractual Obligation) • Medicare Summary Notice (MSN) 60.14 - This claim is being processed under a demonstration project. Services cannot be covered because your doctor does not have a practice in one of the demonstration areas. • Spanish Translation - Esta reclamación está siendo procesada bajo un proyecto de demostración. Los servicios no pueden estar cubiertos porque su médico no tiene una oficina en una de las áreas de la demonstración.									
11870.4.1.1	The contractor shall deny PARHM claims when there is no aligned beneficiary on the claim. The contractor shall use the following messages: • CARC: 96 - “Non-covered charge(s).” • RARC: N83 - (No appeal rights. Adjudicative decision based on the provisions of a demonstration project.) • Group Code: CO • MSN 60.13 - This claim is being processed under a demonstration project. Services cannot									JL A/B MAC, RRB-SMAC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	be covered because you do not reside in one of the demonstration areas. • Spanish Translation- Esta reclamación está siendo procesada bajo un proyecto de demostración. Los servicios no pueden ser cubiertos porque usted no vive en una de las áreas de la demonstración.									
11870.4.2	The contractor shall deny incoming PARHM claims if the Date of Service (DOS) on the claim is prior to January 1, 2021. The contractor shall use the following messages: • CARC: 182- "Procedure modifier was invalid on the date of service." • RARC: N83- (No appeal rights. Adjudicative decision based on the provisions of a demonstration project) • Group Code: CO									JL A/B MAC, RRB-SMAC
11870.4.3	The contractor shall return as unprocessable an incoming PARHM claim if the provider appends the V4 modifier to a HCPCS code that is unrelated to this benefit enhancement. The contractor shall use the following messages: • CARC: 16- (Claim/service lacks information or has submission/billing error(s)) • RARC: N519- (Invalid combination of HCPCS modifiers) • Group Code: CO									JL A/B MAC, RRB-SMAC
11870.4.4	The contractor shall return as unprocessable an incoming PARHM claim when the benefit enhancement is elected by the provider for the DOS on the claim, the claim contains one of the HCPCS codes listed in BR 11870.6 and 11870.7 and the V4 modifier is not appended. The contractor shall use the following messages: • CARC: 16- (Claim/service lacks information or has submission/billing error(s))									JL A/B MAC, RRB-SMAC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• RARC: N822- (Missing Procedure Modifier(s)) • Group Code: CO									
11870.5	The contractor shall process claims as normal FFS claims when there is no aligned provider or V4 modifier present on the claim.									JL A/B MAC, RRB-SMAC
11870.6	The contractor shall process PARHM synchronous telehealth claims with Place of Service (POS) = 2 (Telehealth) when this benefit enhancement is elected by the provider for the Date of Service (DOS) on the claims and when the claim contains the following HCPCS codes: • G0438 • G0439 • G9481 • G9482 • G9483 • G9484 • G9485 • G9486 • G9487 • G9488 • G9489									JL A/B MAC, RRB-SMAC
11870.6.1	The contractor shall deny PARHM claims when this benefit enhancement is elected by the provider for the DOS on the claim, the claim contains one of the HCPCS codes, and the POS is not (2). The contractor shall use the following message: • CARC: 16- (Claim/service lacks information or has submission/billing error(s)) • RARC: M77- (Missing/incomplete/invalid/inappropriate place of service) • Group Code: CO									JL A/B MAC, RRB-SMAC
11870.7	Contractors shall process PARHM asynchronous telehealth claims when this benefit enhancement is elected by the provider for the DOS on the claims and									JL A/B MAC, RRB-SMAC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	when the claim contains the following HCPCS codes: • G9868 • G9869 • G9870									
11870.8	CMS shall send contractors a provider alignment file attached to a technical direction letter that details the participating providers. CMS shall include the following data elements/fields on the provider alignment file: 1. Detail records consisting of: • Record Identifier • PARHM Identifier 2. Provider Type • Preferred= Value P 3. Participating Tax Identifier Number (TIN) 4. Participating NPI 5. Participating CMS Certification Number (CCN) 6. Effective Start Date in the PARHM/Benefit 7. Effective End Date in the PARHM/Benefit NOTE: The PARHM unique identifier is "98".									CMS, JL A/B MAC, RRB-SMAC
11870.9	CMS shall send updated participant alignment files on a quarterly basis.									CMS
11870.10	Contractors shall apply demo code 98 to claims that already have demo codes present on the claim record and place demo code 98 in position 1. NOTE: When demo code 98 is in position 1, editing and processing will only apply for this demonstration.									JL A/B MAC, RRB-SMAC
11870.11	The Medicare contractor shall set a line level edit on an 85X claim with a Condition Code (CC) M6, Revenue code 096x, 097x or 098x, modifier V4 and a					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	HCPCS other than G9481 – G9489, G0438-G0439 or G9868-G9870.									
11870.12	The Medicare contractor shall set a line level edit on an 85X claim with a CC 'M6', Revenue code 096x, 097x or 098x and HCPCS Code G9481 – G9489 or G9868-G9870 and modifier 'V4' is not present.					X				
11870.13	The Medicare contractors shall return to provider (RTP) the claim upon receiving the edit in business requirement (BRs) 11870.11 and 11870.12.									JL A/B MAC
11870.14	CMS shall update the definition of modifier 'V4' to "Provider attests they are billing in accordance with the Telehealth Benefit Enhancement under the Pennsylvania Rural Health Model."									CMS
11870.15	The contractor shall perform secondary Medicare Beneficiary Identifier (MBI) check to ensure the beneficiary is a resident of Pennsylvania (PA).								X	
11870.15.1	The Medicare contractor shall ensure that the permanent address of the beneficiary is in PA when the following criteria are present: • CC 'M6' (institutional claims only) • Type of Bill (TOB) 85X (intuitional claims only) • Revenue code 096x, 097x or 098x (institutional claims only) • HCPCS G9481 – G9489, G0438-G0439, or G9868-G9870 • Modifier 'V4'								X	
11870.15.2	The Medicare contractor shall create a new utilization edit to reject at the line level when one of the following HCPCS G9481 – G9489, G0438-G0439, or G9868-G9870 is present with Revenue code 096x,								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	097x or 098x and a modifier ‘V4’ and the beneficiary’s address is not in PA.									
11870.15.2.1	The Medicare contractor shall allow the new edit to be overridden.								X	
11870.15.2.2	The contractor shall return Trailer “08” identifying the new error code and Trailer “43” identifying the detail line item. NOTE: This edit shall have the ability to be overridden.								X	
11870.15.3	The contractor shall create a new utilization edit for PARHM model professional claims when demo 98 is present, HCPCS Codes G9481 – G9489, G0438-G0439, or G9868-G9870 are present, and the beneficiary address on the bene master record does not have a state code for PA- Pennsylvania. The following conditions will bypass the edit: • Entry code '3' (cancel). • Entry code '9' (add history). • No-pay code or cost avoid present. • The Payment Process Indicator is other that “A”, “R”, “S” or “Z”								X	
11870.15.3.1	The contractor shall return Trailer “08” identifying the new error code and Trailer “39” identifying the detail line item. NOTE: This edit shall have the ability to be overridden.								X	
11870.15.3.2	The contractor shall apply COBA crossover logic when returning Trailer 29 if demo 98 is present on the Part B Professional claim.								X	
11870.16	The contractor shall allow demo code 98 when the claim includes all criteria listed in BR 11870.3.								X	
11870.17	The contractor shall modify consistency edit “0014” to include demo code “98” as a valid demo when received on Part B (HUBC) claims.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11870.18	Contractors shall ensure the claim identifier at the header level will flow to downstream systems including but not limited to: National Claims History (NCH), Integrated Data Repository (IDR), and Chronic Condition Warehouse (CCW).								X	IDR, JL A/B MAC, NCH, RRB-SMAC
11870.19	The Medicare contractor shall reject services at the line level with the Common Working File (CWF) reject in 11870.15.2 with the following: • CARC: 96 (Non-covered Charge(s) • RARC: N83 (No appeal rights. Adjudicative decision based on the provisions of a demonstration project) • Group Code CO (contractual obligation)					X				
11870.20	The Medicare contractor shall continue to allow modifiers that have been previously implemented.					X				
11870.21	The Medicare contractor shall update any existing edits or reason code narratives that might be affected by the enhancement. For example, reason code 36463.					X				
11870.22	The Medicare contractor shall create a new line level reason code to assign when the benefit enhancement telehealth services listed in the CR are billed with modifier V4 and one or more of the following is true: • Claim statement covers from date is not equal to 01/01/2021 or later. • The provider is not a CAH Method II (85X TOB reimbursement method J) participating in the PARHM (M6 condition code is appended to the claim). • The claim does not contain condition code M6 to indicate that the provider is a Pennsylvania Rural Health Model (PARHM) participant. • The revenue code is not 96X, 97X or 98X					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11870.23	The Medicare contractor shall create a new line level edit to assign when the following criteria is present: • TOB 85x • CC 'M6' • Line level date of service is less than 01/01/21 • HCPCS G9481 – G9489 and G9868-G9870					X				
11870.23.1	The Medicare contractor shall allow the new edit to be overridden.					X				
11870.24	Contractors shall generate the new MSN Message 96.12 on claim details identified as related to this benefit enhancement. New MSN Message 96.12: English You got this telehealth service from a provider who is part of the Pennsylvania Rural Health Model (PARHM). For more information about the PARHM, talk with your doctor or call 1-800-MEDICARE (1-800-633-4227). Spanish Usted recibió este servicio de telesalud de un proveedor que forma parte del Modelo de Salud Rural de Pensilvania (PARHM en inglés). Para obtener más información sobre PARHM, hable con su médico o llame al 1-800-MEDICARE (1-800-633-4227).					X				JL A/B MAC, RRB-SMAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11870.25	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09	X	X			

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Ryan Yoder, 410-786-4968 or ryan.yoder@cms.hhs.gov , Adrienne Wiley, 410-786-3087 or adrienne.wiley@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0