Centers for Medicare & Medicaid Services
Medicare Preventive Services National Provider Call:
Five New Medicare Preventive Services
Moderator: Leah Nguyen
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Contents

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Operator: At this time, I would like to welcome everyone to the Medicare Preventive Services National Provider Call: Five New Medicare Preventive Services.

All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for your participation in today's call.

I will now turn the call over to Leah Nguyen. Thank you, ma'am. You may begin your conference.

Introduction

Leah Nguyen: Thank you, Brooke. Hello. I'm Leah Nguyen from the Provider Communications Group here at CMS, and I will serve as your moderator for today's call, which is brought to you by the CMS Medicare Learning Network. I would like to welcome you to our National Provider Call on the Five New Medicare Preventive Services:

1. Screening and behavioral counseling interventions in primary care to reduce alcohol misuse,
2. Screening for depression in adults,
3. Intensive behavioral therapy for cardiovascular disease,
4. Screening for sexually transmitted infections and high-intensity behavioral counseling to prevent STIs, and
5. Intensive behavioral therapy for obesity.

CMS experts will provide an overview of these services, when to perform them, how to perform each service, who is eligible, and how to code and bill for each service, followed by a question and answer session.

Before we get started, there are few items that I need to cover. The slide presentation for today's call was posted on the CMS Web site, and a link to the presentation was e-mailed to all registrants earlier this afternoon. The presentation can also be downloaded from the CMS Fee-for-Service National Provider Calls Web page at www.cms.gov/npc. Again, that URL is www.cms.gov/npc.

At the left side of the Web page, select National Provider Calls and Events, and then select the August 15 call from the list. This call is being recorded and transcribed. An audio recording and written transcript will be posted soon to the National Provider Calls and Events section of the CMS Fee-for-Service National Provider Calls Web page.

At this time, I would like to introduce our speakers for today. We are pleased to have with us Michelle Issa, Jamie Hermansen, and Deirdre O'Connor from the Coverage and Analysis Group Center for Clinical Standards and Quality; Kathy Bryant from the Hospital Ambulatory Policy Group of the Center for Medicare; and Wil Gehne from the Provider Billing Group of the Center for Medicare.

And now it is my pleasure to turn our call over to Michelle Issa for the first presentation on Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse.

Presentation

Michelle Issa: Thank you, Leah.

Effective October 14, 2011, Medicare will cover annual alcohol screening, and for those that screen positive, Medicare covers up to four brief, face-to-face behavioral counseling interventions annually for Medicare beneficiaries, including pregnant women.

Next slide. Slide 8 is the Description of the Service and Our Beneficiary Eligibility.

- For those beneficiaries who screen positive, Medicare covers up to four face-to-face behavioral counseling interventions in a primary care setting.
- For those who misuse alcohol but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence.
- For those who are competent and alert at the time that counseling is provided.
- Whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.

Next slide, number 9: Where Can Eligible Beneficiaries Receive These Services and Who Can Provide Them? Screening and behavioral counseling intervention to reduce alcohol misuse must be furnished by a qualified primary care physician or other primary care practitioners in a primary care setting.

Next slide, slide number 10. For the purposes of this covered service, a primary care practitioner is a physician with specialty designation of general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist; a physician assistant; a nurse practitioner; and a clinical nurse specialist. Thank you.

And I'd like to turn this over to Kathy.

Kathy Bryant: I'm on slide 11. Under the Medicare Program for Code G0442, which is what is used for annual alcohol misuse screening, the national payment rate for physicians in a nonfacility setting, such as a physician's office, would be $17.36. In a facility setting, it would be $9.19. And the hospital outpatient OPPS rate would be $35.69. For all of these services, there is no beneficiary co-insurance or deductible.

For G0443, which is the code that is used for each of the brief face-to-face behavioral counseling sessions, the national payment rates are $25.19 for the physician nonfacility setting, $23.15 for the physician in a facility setting, and, again, $35.69 for the hospital outpatient department. Again, there is no beneficiary co-insurance or deductible.

While we are on the call, I also wanted to point out to you, in slide number 12, a tool that is available on the Web site that you'll be able to use any time to check on these or any other physician payment rates that you may be interested in. It's the Medicare Physician Fee Schedule Search Tool, which you have the link for there, and at this tool, you can put in any CPT or HCPCS code and get all kinds of information, including not only the payment but the payment policy indicators limiting charge, and we keep this updated at least

quarterly so as when we change rates or new codes are added, you can always check here and get that information.

I'm sorry, and now I'd like to turn the call over to Wil.

Wil Gehne: Thanks, Kathy.

On slide 14, we turn to Coding Professional Claims, and before I start, I want to define a couple of terms just for clarity's sake. When the slide titles are referring to Professional Claims, that's referring to claim formats, so that means claims that will be submitted on a CMS 1500 paper claim form or an electronic 837 professional (837P) format.

Each of my billing segments will talk about coding and editing of those professional claims, and then coding and editing of institutional claims, by which I mean claims submitted on the UB04 or the 837i electronic format, and then I'll talk a little bit about editing of all claims.

So going back to professional claims, we are using the two HCPCS codes that Kathy mentioned, G0442 for screening and G0443 for behavioral counseling. And Michelle had mentioned primary care practitioners in a primary care setting, and we identify those things on professional claims using a set of provider specialty types for determining primary care practitioners, and they're listed there on slide 14: general practice, family practice, internal medicine, obstetrics and gynecology, pediatric and geriatric medicine, certified nurse midwife, nurse practitioner, certified clinical nurse specialist, and physician assistant.

Turning to slide 15: The place of service codes that are used to identify primary care settings for the service are: physician's office, outpatient hospital, independent clinic, federally qualified health center, public health clinic, and rural health clinic.

In terms of how Medicare Systems will edit professional claims, we'll ensure that the two G codes are denied if they're not billed with the appropriate place of service code, as was defined, and those denials will be identified on the

remittance advice—the claim adjustment reason code 58, defined as treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service, and remittance advice remark code N428, service/procedure not covered when performed in certain settings.

Similarly, when either code is not billed with one of the defined specialty – provider specialties, the remittance advice for denials will be identified with reason code 185 (rendering provider is not eligible to perform this service billed), and remark code N95 (the provider type/provider specialty may not bill this service). That's on slide 17.

Turning to slide 18, we get the coding for institutional claims – the same two HCPCS codes, G0442 and G0443. We use them on institutional claims. On institutional claims, we are identifying primary care setting by a specific list of types of bill: type of bill 13x for outpatient hospital, 71x for rural health clinic, 77x for federally qualified health centers, and 85x for critical access hospital outpatient.

On slide 19, editing institutional claims – we're similarly ensuring that the two G codes are billed with one of the types of bill I just mentioned, and denials for using other types of bill will be identified under remittance advice with reason code 5 (the procedure code bill type is inconsistent with the place of service) and remark M77 (for invalid place of service).

Next, slide 20. As the facilities in the audience will be familiar, the Medicare payment basis for institutional claims, you know, varies by the facility type: hospital outpatient claims, paid under the Outpatient Prospective Payment System; RHC and FQHC claims paid under all-inclusive payment rate; and critical access hospital claims paid based on the payment method that's selected by the hospital. If they select method I, we pay 101 percent of reasonable cost for technical component of the service, with the professional component able to be billed separately, and if they elect method II, 101 percent of the reasonable cost for the technical component plus 115 percent of the nonfacility rate for the professional component of those services.

And any time we have payments that are covered by an all-inclusive rate, as in our RHC and FQHC settings, we have the question of what can be paid separately from an encounter or what is bundled into the payment for an encounter. So turning to slide 21, there are some special instructions for RHC/ FQHC payment, and that is that the alcohol screening and counseling is usually not separately payable with another encounter or visit on the same date. So on those claims, a separate service line is reported so that we can carve out the charges from the co-insurance and deductable, which Kathy mentioned don't apply to the service, but Medicare systems will bundle the line with the encounter and share that on the remittance advice with reason code 97, indicating that thee benefit for this service is included in the payment for another service.

Turning to slide 22 – a couple of terms, additional terms to define, when we talk about frequency editing in the slides that follow. By "professional services," we mean any professional claim as I defined them earlier, plus any institutional claims that's billed with RHC or FQHC bill types, or institutional claims with the type of bill 85x that show institutional service revenue codes – revenue codes 096x, 097x, or 098x. "Facility fee claims" will be, you know, pretty much anything that's left – types of bill 13x and 85x, where the professional service revenue codes are not reported.

Slide 23 turns to editing that applies to both professional and institutional claims. All claims for these services we'll be editing to ensure that G0442 is not billed more than once in a 12-month period, and G0443 is not billed more than four times in a 12-month period. And the remittance advice coding for those denials that exceed those maximums would be reason code 119, which is "benefit maximum for this period has been reached," or the remark code N362, which is "the number of days or units exceed our acceptable maximum." For each of those limits, a professional service or facility fee, as I described them, can be billed separately.

Slide 24 describes editing to ensure that G0443 is not billed more than once on the same date of service for the same beneficiary, and denials for that reason will be identified on remittance advices with reason code 151,

"payment adjusted because the payer deems the information submitted does not support this many of the frequency of services" and remark code M86, "service denied because the payment is already made for a similar procedure within the set timeframe."

And finally, turning to slide 25: We will also edit to ensure that the screening code G0442 is in the beneficiary's paid claims history before any claims for G0443 can be paid, and if that condition isn't met, the remittance advice will be coded with claim adjustment reason code B15, "the service requires that qualifying service be received and covered, the qualifying service has not been received or adjudicated," and remark M16 with an alert to see the contractor's Web site for the details, (inaudible), regarding this. Leah?

Leah Nguyen: Thank you, Wil. There's a list of resources for Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse on slide 26. And now I would like to turn the call back over to Michelle Issa, with our presentation on Screening for Depression in Adults.

Michelle Issa: Thanks, Leah.

Effective October 14, 2011, Medicare covers annual screening for adults for depression in a primary care setting that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and followup.

Next slide, number 29. Screening – up to 15 minutes for depression screening for Medicare beneficiaries in a primary care setting when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and followup. At a minimum level, staff-assisted supports consist of a clinical staff – for example, a nurse or physician assistant in a primary care setting who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment.

Various screening tools are available for screening for depression. CMS does not identify specific depression screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in a primary care setting.

Next slide, number 30. For the purposes of this benefit, a primary care setting is a setting where there is provision of integrated, accessible healthcare services by clinicians who are accountable for addressing large majority of personal health care needs, development of sustained partnership with patients, and practicing in the context of family and community.

Next slide, Coverage Limitations, slide 31. Screening for depression is not covered when performed more than one time in a 12-month period. It does not include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression, nor does it address therapeutic interventions such as pharmacotherapy, combination therapy, counseling and medications, or other interventions for depression. Self-help materials, telephone calls, and Web-based counseling are not separately reimbursable by Medicare and are not part of this national coverage determination.

Thank you. Now I'd like to turn it over to Kathy.

Kathy Bryant: Thank you.

For HCPCS code G0444 – is the code used for annual depression screening. The national payment rates, again, starting with the physician nonfacility rate is $17.36. For the physician providing a service in the facility, $9.19. The hospital outpatient rate is $35.69. And there is no beneficiary co-insurance or deductible for this service.

Now, I'll turn it over to Wil.

Wil Gehne: Thanks, Kathy.

For coding of depression screening on professional claims, you would use HCPCS Code G0444, and in this case the associated place of service code list is a little bit more limited – limited to physician's office, outpatient hospital, independent clinic, or public health clinic. Similar to the other benefits, the Medicare system is going to edit to ensure that the correct place of service is reported, and if it's not, the remittance advice will show that with reason code 58 and the remark code N428. And for the place of service edits, the

remittance advice coding is consistent across all five of these benefits. We'll move through that a little bit more quickly as we go along.

Regarding coding institutional claims, the same HCPCS would be used, and the same list of type of bills is allowable that we had seen in the previous benefits and Medicare systems (turning to slide 36) and, again, edit to ensure that. In this case, we have slightly different remittance advice coding for those denials using reason code 170, which is that "payment is denied when performed or billed by this type of provider," and remark code N428, "not covered when performed in this place of service." So for the institutional claim edits, the remittance advice coding varies slightly between the benefits.

Once again, the payment basis on slide 37 varies by facility type. This is consistent across all five of the benefits. We'll move through that a little bit more quickly as we go along as well.

Turning to all claims again on slide 38: Medicare systems enforce that annual depression screening is billed no more than once within a 12-month period. Whenever there are time limitations like that it's important to get the specific definition of how that's enforced, and we're using 11 full months that must elapse following the month in which the last annual depression screening took place.

On slide 39, you can see that when that edit is applied, the remittance advice will indicate it with reason code 119, "benefit maximum for this time period or occurrence has been reached," and remark code N362, "the number of days or units of service exceeds our acceptable maximum." And once again, professional and facility fees can be billed separately for the services just as we defined them back on slide 22.

Leah?

Leah Nguyen: Thank you, Wil.

There's a list of resources for Screening for Depression in Adults on slide 40.

At this time, we will pause for just a few minutes to complete keypad polling so that CMS has an accurate account of the number of participants on the line with us today. Please note: There may be moments of silence while we tabulate the results.

Brooke, we're ready to start polling.

Polling

Operator: CMS greatly appreciates that many of you minimized the government's teleconference expense by listening to these calls together in your office using only one line. Today, we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number between 2 and 8. If there are nine or more you in the room, enter 9. Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number between 2 and 8. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling.

Please continue to hold while we complete the polling.

This completes the polling. You may proceed.

Leah Nguyen: Thank you, Brooke.

I'll now turn the call over to Jamie Hermansen with our presentation on Intensive Behavioral Therapy for Cardiovascular Disease.

Presentation (Continued)

Jamie Hermansen: Thank you, Leah.

Effective November 8, 2011, Medicare covers intensive behavioral therapy for cardiovascular disease, which is also referred to as a CVD risk reduction visit. The visit consists of three components:

1. Encouraging aspirin use for primary prevention of cardiovascular disease,
2. Screening for high blood pressure, and
3. Intensive behavioral counseling to promote a healthy diet.

Medicare covers one face-to-face CVD risk reduction visit each year.

On slide 43, Medicare Part B covers the CVD risk reduction visit for Medicare beneficiaries who are competent and alert at the time counseling is provided and whose counseling is furnished by a qualified primary care physician or primary care practitioner and in a primary care setting.

Slide 44. For purposes of this covered benefit, a primary care practitioner is a physician with a specialty designation of general practitioner, family practice practitioner, general internist, obstetrician or gynecologist, physician assistant, nurse practitioner, or clinical nurse specialist.

Slide 45. For purposes of this covered benefit, a primary care setting is defined as one in which there is a provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing within the context of family and community.

I would now like to hand the call over to Kathy Bryant.

Kathy Bryant: For the intensive behavioral therapy to reduce cardiovascular disease, individual, face-to-face counseling, you use code G0446. The national payment rates for the physician in an office or other nonfacility setting is $25.19, for a physician in a facility setting is $23.15, and for the hospital outpatient department is $35.69. There is no beneficiary co-insurance or deductible.

Now, I'll turn it over to Wil.

Wil Gehne: Thanks, Kathy.

Turning to slide 47 regarding professional claims: You'd use the HCPCS code that Kathy just mentioned, G0446, and in this case, one of the provider specialty types from the longer list that we saw on the alcohol NCD – I don't want to read the entire list again, but you have it there on slide 47.

And on slide 48, the same list of place of service codes that we saw on the last benefit.

Slide 49: Again, it's very consistent. We have the same two edits for ensuring that those provider specialty types and places of service are reported, and the remittance advice coding for those two denials is identical to the two that we saw before.

Regarding institutional claims on slide 50, use G0446 and one of the – what's now a familiar looking list of types of bill, that you see there on slide 50.

And on slide 51, we'll be editing to ensure that service is limited to those types of bill, and coding the remittance advice for any denials with reason code 170 and remark code N428.

Slide 52: Once again, the payment varies, and the information there is similar to what you saw, or identical to what you saw, on the earlier slide.

Slide 53, regarding editing of all claims for Medicare systems, we'll be editing to ensure that the G0446 is billed no more than once in a 12-month period using that same criterion of 11 full months following the service month, and we'll be coding remittance advice for denials in the same way that we did for the depression screening, with reason code 119 and remark code N362. And once again, professional and facility fees can be billed separately for the service.

Leah?

Leah Nguyen: Thank you, Wil.

There's a list of resources for intensive behavioral therapy for cardiovascular disease on slide 54.

I will now turn the call over to Deirdre O'Connor for our presentation on screening for sexually transmitted infections and high-intensity behavioral counseling to prevent STIs.

Deirdre O'Connor: Hi. On slide 56, there is the description of the service. So, effective for dates of service on or after November 8, 2011, CMS will cover screening for sexually transmitted infections – specifically chlamydia, gonorrhea, syphilis, and hepatitis B – with the appropriate Food and Drug Administration–approved/cleared laboratory tests when ordered by the primary care provider.

The tests must be used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act regulations and performed by an eligible Medicare provider for these services.

Who is covered and frequency?

Screening for chlamydia and gonorrhea:

- Pregnant women who are 24 years old or younger when the diagnosis of pregnancy is known, and then repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test,
- Pregnant women who are at increased risk for STIs when the diagnosis of pregnancy is known, and then repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test, and
- Women at increased risk for STIs, annually.

For syphilis:

- Pregnant women when the diagnosis of pregnancy is known, and then repeat screening during the third trimester and at delivery if high-risk sexual behavior has occurred since the previous screening tests,
- Also, men and women at increased risk for STIs annually.

For hepatitis B:

- Pregnant women at the first prenatal visit when the diagnosis of pregnancy is known, and then re-screening at the time of delivery for those with new or continuing risk factors.

The coverage policy for the high intensity behavioral counseling is effective for dates of service on or after November 8, 2011. CMS will cover individual, 20- to 30-minute, face-to-face counseling sessions for Medicare beneficiaries for high-intensity behavioral counseling to prevent STIs, if referred for this service by a primary care provider and provided by a Medicare-eligible primary care provider in a primary care setting.

Slide 61, Description of Primary Care Practitioner. Primary care practitioner is described as a physician with a specialty designation of general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist; physician assistant, nurse practitioner, or clinical nurse specialist.

A setting where there is a primary care setting is described as provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal health care needs, development of sustained partnership with patients, and practicing in context of family and community.

Slide 63 is – high-intensity behavioral counseling is defined as a program intended to promote sexual risk reduction or risk avoidance, which includes each of these broad topics, allowing flexibility for appropriate patient-focused elements: education, skills training, and guidance on how to change sexual behavior. The medical record should be a reflection of the service provided, and I would refer you to the MLN Matters article on National Coverage Determination on slide 80 for a complete description of who is considered at high or increased risk.

CMS will cover up to two individual, 20- to 30-minute, face-to-face counseling sessions annually for all sexually active adolescents and for adults at increased risk for STIs.

And now, I'll hand it over to Kathy.

Kathy Bryant: Thank you.

For the high-intensity behavioral counseling to prevent sexually transmitted infections, you use code G0445, and that code includes education, skills training, and guidance on how to change sexual behavior. The national payment rates for each of those services: for a physician in a nonfacility setting, $25.19; for a physician in a facility setting, $23.15; and the OPP hospital outpatient rate is $35.69. There is no beneficiary co-insurance or deductible for these services.

Now, I'll turn it over to Wil. Oh wait, I'm sorry. I won't turn it over to Wil. I also wanted to mention that for the screening, the clinical lab tests are also covered for chlamydia, gonorrhea, syphilis, and hepatitis B. Those are paid under the clinical lab fee schedule, and on slide 66 we've provided you with the link to get that exact information, depending upon the (inaudible) you would be using.

And now, I'll turn it over to Wil.

Wil Gehne: Thanks, Kathy.

Starting at slide 67, regarding coding professional claims, you'd use the G0445 code that Kathy mentioned, and for this service we have an additional requirement, that the reporting HCPCS code needs to be supported by a specific ICD-9 diagnosis code, and that is code V69.8.

At the bottom of slide 67, you see the now-familiar list of provider specialty types that are required, and again on slide 60 – I'm sorry, on 67 you see that, and again on 68, you see the list of place of service codes that are accepted.

Slide 69 indicates that, once again, we're editing to ensure that those specialty types and places of service are reported accurately on the claim, and the remittance advice coding is consistent with what we've talked about before.

Regarding coding institutional claims, on slide 70, the same HCPCS code is used, and the same ICD-9 code requirement for V69.8 applies. The familiar list of types of bill is in effect here as well, and on slide 71, you see that the

remittance advice coding for any denials for other types of bill uses reason code 170 and remark code N428.

Once again, on slide 72, the payment varies by facility type, and the special instructions for RHCs and FQHCs apply.

For editing of all claims, we ensure that the G0445 is billed with the diagnosis code V69.8, and denials for the absence of that diagnosis code will be reported with reason code 50. They're not – these are noncovered services because this is not deemed a medical necessity by the payer, and remark code N386, indicating that this physician was based on a national coverage determination.

We'll also be editing to ensure that G0445 is billed no more two sessions in a 12-month period, and any denials for that reason will be coded using the benefit maximum codes that we've seen earlier in the presentation. And once again, facilities are – professional services and facility fees can be billed separately when applying those frequency limitations.

For this service, as Kathy mentioned, we have coding for laboratory billing as well, and I don't want to read the long list of HCPCS codes that are shown on slide 75, but note that there are nine different codes for chlamydia testing, four for gonorrhea, three for syphilis, two for hepatitis B, and those HCPCS code can be supported by ICD-9 codes V74.5, V73.89, V69.8, V22.0, V22.1, or V23.9.

A list of valid ordering provider specialties for those lab codes is similar to the list of – identical to the list of provider specialties that we've seen on several of the other services and shown on slide 76.

Medicare systems edits to the laboratory billing will be ensuring that the STIs are billed with the appropriate ICD-9 diagnosis code that I just mentioned, and denials for the lack of these diagnostic codes would use reason code 50 and remark code N386.

On slide 78, we'll be ensuring that the ordering physician specialty is appropriate for screenings for STIs, and those denials would be indicated on remittance advice with reason code 184, "the prescribing or ordering provider is not eligible to prescribe or order the service billed."

On slide 79 notes that we'll also be editing to ensure that those screenings for STIs do not exceed coverage frequency limitations as they had noted with coverage frequency differs based on the test performed, patient gender, high-risk diagnosis, and pregnancy status, and the benefit maximum remittance advice coding that we've seen on earlier slides applies to these services as well.

Leah?

Leah Nguyen: Thank you, Wil. And again, there's a list of resources for screening for sexually transmitted infections and high-intensity behavioral counseling to prevent STIs on slide 80.

I will now turn the call over to Jamie Hermansen for our final presentation on intensive behavioral therapy for obesity.

Jamie Hermansen: Thank you, Leah.

On slide 82: Effective November 29, 2011, Medicare covers intensive behavioral therapy for obesity for beneficiaries with a body mass index greater than or equal to 30. Intensive behavioral therapies for obesity consist of the following: a screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters, dietary nutritional assessment, and intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high-intensity interventions on diet and exercise.

On slide 83: For Medicare beneficiaries with obesity who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting, CMS covers one face-to-face visit every week for the

first month, one face-to-face visit every other week for months 2 through 6, and one face-to-face visit every month for months 7 through 12, if the beneficiary meets the 3 kg weight loss requirement during the first six months.

For slide 84: At the six-month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed. Beneficiaries must lose 3 kg during the first six months of counseling to be eligible for counseling for an additional six months. Beneficiaries who do not achieve a weight loss of 3 kg or more may undergo reassessment of their readiness to change and BMI after an additional six months period.

On slide 85: This service must be furnished in a primary care setting by a primary care practitioner.

For slide 86: For purposes of this covered benefit, a primary care practitioner is a physician with specialty designation of general practitioner, family practice practitioner, general internist, obstetrician or gynecologist; a physician assistant, nurse practitioner, or clinical nurse specialist.

For slide 87: For purposes of this covered benefit of primary care setting is to find those one in which the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing within the context of family and community.

For slide 88 and 89: The decision – the decision covers intensive behavioral therapy for obesity when furnished in primary care settings, as described in Section 210.12 of the Medicare National Coverage Determinations Manual. In the primary care office setting, Medicare may cover these services when billed by the primary care physician or practitioner and furnished by auxiliary personnel under the conditions specified under our regulation at 42 CFR section 410.26(b). In the primary care hospital outpatient setting, Medicare may cover these services when furnished and billed by the primary care physician or practitioner, as described in Section 210.12 of the Medicare National Coverage Determinations Manual.

In addition, Medicare may cover these services when furnished by the hospital in outpatient hospital settings under the conditions specified under our regulation at 42 CFR 410.270. We believe that providing for coverage under these conditions will promote appropriate staff to furnish intensive behavioral therapy for obesity while ensuring that services are delivered within the primary care setting in order to provide a coordinated approach as part of each patient's comprehensive prevention plan.

I would now like to hand the call over to Kathy Bryant.

Kathy Bryant: Thank you. For the face-to-face behavioral counseling for obesity, use code G0447. For physician rates in a nonfacility setting, it is at $25.19; for the physician rate in a facility setting, it's $23.15; and for the OPPS rate, it is $35.69. There is no beneficiary co-insurance or deductible for this service.

Now, I'll turn it over to Wil.

Wil Gehne: Thanks, Kathy.

When coding professional claims using the G0447, once again there is a diagnosis coding requirement. In this case, a range of codes – one of a range of codes must be used, all indicating body mass index is over 30 – that's V85.30 through 39, or V85.41 through 45 – and again those services – the combination of procedure and diagnosis codes needs to be billed by one of the provider types – I mean provider specialty types – that's shown on slide 90, and by one of the places of services codes – place of service codes, that's shown on slide 91.

We'll be editing to ensure the specialty types and place of service codes on slides 92 and 93 using the same remittance coding that has been consistently applied for all the benefits we've talked about today.

On slide 94, Coding Institutional Claims: The same requirement for a HCPCS code and a code from the diagnosis range of V85.30 through 39 or V85.41 through 45 applies, and the familiar list of types of bill must be used.

When Medicare systems are editing to ensure institutional claims are using the appropriate type of bill for this service, the remittance advice coding varies back to using adjustment reason code 5 and remark code M77.

And once again on slide 96, the payment for the service varies by the type of bill.

On slide 97: Medicare claim system edits that apply to all claims – we're ensuring that G0447 is billed with one of those specified diagnosis codes, and remittance advice codes for denial are reason code 167, "these diagnosis codes are not covered," and remark code N386, indicating that the decision was based on a national coverage determination.

We're also editing, on slide 98, to ensure the frequency limitation. Jamie described – the frequency limitation varies over time by month, and because we can't be sure in Medicare systems that services are coming in sequentially, we can't enforce that requirement exactly, but we can sure enforce systematically that the absolute limit for a 12-month period is met, and so we're ready to ensure that G0447 is billed no more than 22 times during a 12-month period, and if that condition is exceeded – that limit is exceeded, using the benefit maximum remittance advice coding that we've seen several times in the earlier presentation.

One last thing I'd like to note, and this applies to all five of the benefits we've talked about today, next eligible dates for the services that have been described are viewable through standard inquiry methods. So if you're not certain whether a beneficiary is eligible on a given date, you can check through one of the standard inquiry methods and get the date that is appropriate.

Thanks.

Leah Nguyen: Thank you, Wil.

There's a list of resources for intensive behavioral therapy for obesity on slide 100.

On slide 101, we have information on how to submit comments for the calendar year 2013 Physician Fee Schedule proposed rule, and on slide 102 there's a list of general preventive services resources.

It is now time for our question and answer session. Let me take this time to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many participants as possible, we ask that you limit your question to just one.

Brooke, we're ready to take our first question.

Question and Answer Session

Operator: Thank you for your participation. We will now move into the Q&A session for this call. To ask a question, please press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking your question, and pick up your handset before asking your question to assure clarity.

Please note your line will remain open during the time you're asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question comes from (Susan Gingrich).

(Susan Gingrich): For the G codes that did not have indicated diagnosis codes, is there an LCD that lists the covered codes?

Leah Nguyen: Could you hold on for a moment?

(Susan Gingrich): Hello?

Yvette Cousar: This is Yvette Cousar. If you're unsure – You would use whatever diagnosis code is appropriate, and if you're unsure, you could contact your provider – I mean, your local contractor when you submit your claims.

(Susan Gingrich): OK. Thank you.

Leah Nguyen: You're welcome.

Operator: Your next question comes from JoNell Hintz.

JoNell Hintz: Hi. We have a question on intensive behavioral therapy for obesity. We are practicing in a provider-based setting, and we're wondering if a dietician can bill incident to a physician in that setting?

Jamie Hermansen: Thank you. That's a great question. As we referred on slides 88 and 89, the decision covers intensive behavioral therapies and for obesity when furnished in a primary care setting, as described in section 210.12 of the Medicare National Coverage Determination Manual. In the primary care office setting, Medicare may cover these services when billed by the primary care physician or practitioner and furnished by employee personnel under the condition specified under a regulation at 42 CFR, Section 410.26(b).

In the primary care hospital outpatient setting, Medicare may cover these services when furnished and billed by the primary care physician or practitioner as described in Section 210.12 of the Medicare National Coverage Determinations Manual. In addition, Medicare may cover these services when furnished by the hospital in outpatient hospital settings under the conditions specified under our regulation at 42 CFR Section 410.27.

We believe that providing for coverage under these conditions will permit appropriate staff to furnish intensive behavioral therapy for obesity while ensuring that services are delivered within the primary care setting in order to provide a coordinated approach as part of each patient's comprehensive prevention plan.

Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Connie Stubbs.

Connie Stubbs: Hi. This is Connie from Practice Plus. My question is: Can these behavioral services be billed in the physician office setting on the same day as another E&M visit, such as patient coming in for, you know, checkup of chronic problem?

Kathy Bryant: This is Kathy Bryant. There are no specific restrictions that would prohibit these services from being billed in general on the same day as an E&M service. You would have to meet entirely the requirements for billing both services, so there could be no overlap in the services provided.

Connie Stubbs: OK. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from CarolAnn Schilz.

CarolAnn Schilz: Good afternoon. This is Carol Ann from Billings Clinic. On the same question just asked, can you do any of these services – provide any of these services with the annual wellness visit or the welcome to Medicare visit? Other than the depression screening; I know that one you can't.

Kathy Bryant: Again, Kathy Bryant. That same general answer applies. Yes, they can be done on the same day, but they need to be entirely distinct. So you can't overlap the services, and you need to bill and code appropriately for each service performed.

CarolAnn Schilz: OK. Thank you.

Operator: Your next question comes from Carmen Malinas.

Carmen Malinas: Hi. Are these services for a PA billing follow the incident II rule?

Leah Nguyen: Could you hold on for a moment?

Jamie Hermansen: Hi. This is Jamie Hermansen. Please refer back to slides 88 and 89.

Leah Nguyen: Thank you.

Operator: Your next question comes from Carolyn Roberts.

Carolyn Roberts: Hi. This is Carolyn Roberts from Baystate Medical Practices. I have a question on what needs to be documented at these visits. These are all time-based codes, and I don't see anything in the guidance here that says that time must be documented.

Kathy Bryant: Hi. This is Kathy Bryant. We don't have specific documentation requirements that apply just to these codes. So as with all codes, you would need adequate documentation if you were audited to demonstrate that you met the requirements to bill the particular code that you billed.

Carolyn Roberts: So you just need adequate documentation. I mean, all other codes that are time-based, we have to fulfill documentation requirements of the amount of time spent by – or face-to-face – you know, the ones that are face-to-face counseling. We have to show that these are face-to-face visits. We also have to show that the time requirement was met as long as, like, a content of the counseling service – what they talked about, discussed, trained, and educated.

Kathy Bryant: Again, there are no special documentation requirements for these that are different than the documentation requirements that would be applied to other codes. So if you were audited, you would need to demonstrate that you met the requirements of billing this particular code.

Carolyn Roberts: OK. Thank you. Would you take another question, or no?

OK. All right. I'll call back if there's any time at the end.

Leah Nguyen: Thank you.

Carolyn Roberts: Thank you.

Operator: Your next question comes from Kathy Wolf.

Kathy Wolf: Hi. This is Kathy Wolf and I'm with Peter Clark, M.D., and this is regarding the intensive behavioral therapy for obesity. I wanted to know if this can be done in the context of a group visit and if the patient, if – outside of a group

visit, if a patient doesn't want to come in for all those services, the entire series, can you still bill for a reduced number of services?

Jamie Hermansen: Hi. This Jamie Hermansen again. If you could do us a favor and e-mail that question in to us, that would be great. We'd get back to you. The e-mail address is preventionnpc@cms.hhs.gov, and then we can respond – then we can follow up with you on that.

Kathy Wolf: OK.

Leah Nguyen: It's listed on slide 105.

Kathy Wolf: It's preventionnpc@cms.hhs.gov.

Jamie Hermansen: That's correct. And it's also listed on slide 105.

Kathy Wolf: Slide 105. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Linda Potter.

Linda Potter: Yes, Linda Potter with Aquidneck Medical Associates. Can – in regards to the alcohol screening, can you bill the G0442 and the G0443 on the same date of service?

Yvette Cousar: This is Yvette Cousar. Yes, you may.

Linda Potter: OK. Now, can you do that more than once? Oh, no. Never mind. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Joann Rubel. Joann, your line is open.

The question has been withdrawn. Your next question comes from Maggie Amero.

Maggie Amero: Yes. In regards to a question someone asked earlier about the screening services being billable with the annual wellness visit and the IPPE – in the materials that were linked to in the e-mail, the screening for depression is actually listed as a standalone benefit, separately billable with the IPPE and the AWV. Is that correct?

Leah Nguyen: Hold on for one minute.

Maggie Amero: OK.

Leah Nguyen: Could you send that question to our resource box listed on slide 105?

Maggie Amero: Sure.

Leah Nguyen: OK. Thank you.

Maggie Amero: Sure.

Operator: Your next question comes from Maureen Everhart.

Maureen Everhart: Hi. Maureen Everhart, Gary Gilcrease, M.D., P.A., and my question is regarding slide 21, which has to do with the alcohol screening and counseling, which says it's not separately payable. The exception does list to the welcome to Medicare. Does that mean it cannot be done with the other annual Medicare, and would we modify that with a 25?

Wil Gehne: Well, first I want to note that that instruction is specific to the rural health clinic and federally qualified health centers.

Maureen Everhart: OK.

Wil Gehne: But yes, the only exception is for the IPPE …

Maureen Everhart: OK.

Wil Gehne: … IPPE visit, not for the annual wellness.

Maureen Everhart: All right.

Wil Gehne: That will be paid as a single encounter.

Maureen Everhart: OK. All right. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Julia Reyes.

Julia Reyes: Hi. This is Julia. Somebody actually already asked my question, so it's been addressed. Thank you.

Operator: Your next question comes from Jerrold Kaminski.

Jerrold Kaminski: Hi. This is Jerrold Kaminski from the office of Dr. Lois Shulman. Is there a different pay rate for participating versus nonparticipating physicians?

Leah Nguyen: Could you hold on for a moment?

Jerrold Kaminski: Sure.

Kathy Bryant: Hi. This is Kathy Bryant. And yes, as with all Medicare services, there is a difference between the participating and the nonparticipating physician rates.

Jerrold Kaminski: So which amount is billed, and how would we know what the difference is?

Kathy Bryant: The instructions – I believe, if you go to the Medicare search tool, you can get that complete information.

Jerrold Kaminski: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Judy Hood.

Judy Hood: Hi. This is Judy Hood with Northwest Health Services. My question is about the behavioral therapy for obesity, and what if during the course of this therapy, the patient's BMI drops below 30?

Jamie Hermansen: Hi. This is Jamie Hermansen. Again, if you could please e-mail that question in to us, we can follow up with you after the call.

Judy Hood: OK. Thank you.

Jamie Hermansen: Thanks.

Operator: Your next question comes from Denita Johnson.

Denita Johnson: Hi. This is Denita Johnson, calling from IU Health Physicians, and my call is in regards to the intensive behavioral therapy, IBT. I was wanting to know, if the patient is coming in – and let's say we're billing an annual wellness visit, because according to the material, the IBT can be billed alone –do we have to link the BMI, which is one of the V85.0 codes, to the G0447 as primary, or could we link the V70.0 as a primary diagnosis with the IBT?

Hello?

Leah Nguyen: Hold on for one moment please.

Denita Johnson: OK.

Leah Nguyen: Hello. Could you just e-mail that to our resource box on slide 105?

Denita Johnson: OK.

Leah Nguyen: We'll get an answer right back to you.

Denita Johnson: OK. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Leslie Anglesey.

Leslie Anglsey: Yes, this is Leslie from Pocatello Women's Health Clinic. We have certified nurse midwives on staff, and slide 47 in Wil's presentation, where – on cardiovascular screenings, certified nurse midwives aren't listed there separately, whereas in some of the other sections, they were particularly

named. Is that right – that certified nurse midwives cannot bill for the cardiovascular G0446?

Leah Nguyen: Hello. Could you send that to our resource box on slide 105?

Wil Gehne: Wait a minute.

Leslie Anglesey: Yes.

Leah Nguyen: All right. Hold on one moment.

Leslie Anglsey: OK.

Wil Gehne: It turns out – thank you for pointing that out. It turns out that was an oversight in that slide, and the certified nurse midwives should be listed along with the other provider specialty types on slide 47.

Leslie Anglesey: Thank you so much.

Leah Nguyen: Thank you.

Operator: Your next question comes from Della Flanagan.

Della Flanagan: Della Flanagan, Concord Hospital. I'm on the conference call, and I heard the question about intensive behavioral therapy for obesity, but I'm still not clear on the answer. Is a dietician considered auxiliary personnel for slide 88 and 89?

Jamie Hermansen: I would – and this is Jamie Hermansen again – and I think you have a great question, but I would also refer you back to slide 88 and 89 regarding that particular question.

Della Flanagan: I've been to that slide, and I'm still not clear, though. That's the question.

Jamie Hermansen: If you would have additional questions, you're welcome to send that in to our e-mail box.

Della Flanagan: OK. Thank you.

Jamie Hermansen: Thank you.

Operator: Your next question comes from Stacey Miller.

Stacey Miller: Hi. Stacey Miller at Carolinas HealthCare Systems. Back to the, in particular, the alcohol screening, and maybe some of the other behavioral screening, and we did answer the question about having it performed in addition to another E&M service on that day – a separately identifiable problem or that sort of thing. But I was wondering about – the slide that says modifier 59. Typically we're used to billing that G code with a modifier 25 or – excuse me, with a modifier 25 on the E&M code. Is that acceptable, or should we be using modifier 59 in that instance?

Wil Gehne: Hi, it's Wil. Which slide are you referring to?

Stacey Miller: Slide 21.

Wil Gehne: OK. Then …

Stacey Miller: … exceptions to not billing a separately payable encounter.

Wil Gehne: And you're an RHC or an FQHD?

Stacey Miller: No. Actually, I missed that part – a physician office. Sorry about that. So in a physician office, would you bill 25 on the E&M with the separate diagnosis and then a G code for the alcohol counseling or screening?

Leah Nguyen: Can you hold on for a moment?

Stacey Miller: Sure.

Yvette Cousar: Hi, this is Yvette Cousar. You would have to check with your contractor where you resubmit your claims on billing the E&M service with a modifier.

Stacey Miller: OK. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Diane Dauksas.

Diane Dauksas: Hi. This is Diane Dauksas and I work for Dr. Charles Godoshian's office, and I just had a question regarding the alcohol screening. The code G0444 states up to 15 minutes. We usually give the patient a PHQ-9 form to fill out at home, and then they bring that back with their visit. If they answer that they are not bothered by any of the problems – there's like 10 questions listed – are we still able – the physician still goes over the screening questionnaire with them, but if they answered that they're not bothered by any of the problems, are we still able to bill for this?

Kathy Bryant: This is Kathy Bryant. The service is for screening, so you're eligible to be paid for performing the screening, whether – regardless of whether the patient has screened positive or negative. The question of the work done by – whether the work done by the physician meets the code required is a separate one.

Diane Dauksas: OK. Thank you so much.

Operator: Your next question comes from (Linda Westman).

(Linda Westman): Yes. My question was: Will the Medicare eligibility screen notify providers when – when some of these services have been performed?

Wil Gehne: Generally speaking, they won't notify you about when the service has been performed, but they'll provide the next eligible date for when the service can next be performed.

(Linda Westman): Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Erica Schwalm.

Erica Schwalm: Hi. This Erica from Hampden County Physician Associates. Going back to whether or not these services can be billed with E&M services, I kind of feel like you guys are giving contradicting information, because when the National

Correct Coding Initiatives were updated in July, all the G codes were bundled into all other E&M services. So I guess I'm seeking clarification. Are you saying that it's OK to bill these with the modifier 59 to override the edits?

Leah Nguyen: Could you hold on for one moment please?

Thank you. Could you go ahead and submit that to the resource box on slide 105 for us?

Erica Schwalm: Sure. And as far as everybody else submitting questions, I'd like to hear – are the answers going to be posted online somewhere?

Leah Nguyen: Yes. We're going to prepare a question and answer document from the call, and we will send out a listserv when that's available and post it on the NPC Web site, and we'll also send an e-mail to all the call registrants to let you know when it's ready.

Erica Schwalm: OK. Great. Thank you very much.

Leah Nguyen: You're welcome.

Erica Schwalm: OK.

Operator: Your next question comes from Debbie Tisonyai.

Debbie Tisonyai: Hi. Debbie Tisonyai from Quality Care Partners. I just have a question regarding the cardiovascular disease risk assessment. On slide 42, I believe it was, it mentions that it can be performed year – can be done yearly. Slide 43 or 46 says that it's biannual. So I just needed to know – is that once a year or twice a year?

Jamie Hermansen: It's once per year. This is Jamie Hermansen.

Debbie Tisonyai: OK. Alright. Thank you.
Leah Nguyen: Thank you.

Operator: Your next question comes from Andrew Chesson.

Andrew Chesson: Hi. This is Andrew Chesson at Maiden Family Practice. The question about the dash 15 minute on the G0442 and G0446: As long as the criteria are met, is that up to 15 minutes, or is that a full 15 minutes or more?

Leah Nguyen: Hold on for one minute.

Yvette Cousar: Hi, this is Yvette Cousar. It's up to 15 minutes.

Andrew Chesson: On both G0442 and G0446?

Yvette Cousar: Yes.

Andrew Chesson: OK. Thank you.

Operator: Your next question comes from (Molly Snedly).

(Molly Snedly): Hi. I'm (Molly) in (Inaudible) Medical Center, and what rev codes should an FQHC use?

Leah Nguyen: Hello. Could you repeat your question?

(Molly Snedly): Yes. What rev codes should an FQHC facility use?

Wil Gehne: You use the same revenue codes that you use to – for reporting the ….

(Molly Snedly): Preventive?

Wil Gehne: … encounters typically.

(Molly Snedly): Oh, just from our regular encounters?

Wil Gehne: Yes.

(Molly Snedly): Yes. OK. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Julie Hamilton.

Julie Hamilton: Hi. Julie Hamilton at Institute for Progressive Medicine. I have a question regarding the screening STI lab tests. Does the physician have to perform the G0445 in order to order those screening STI tests, or can he perform a regular E&M service, and then order those screening STI tests?

Felicia Rowe: This is Felicia Rowe. No, you don't have to perform the (high VC) counseling in order to order the STI lab tests. A regular encounter will do for ordering the STI lab tests.

Julie Hamilton: OK. Thank you so much.

Leah Nguyen: Thank you.

Operator: Your next question comes from Lori Minert.

Lori Minert: Yes. I'm Lori from Mercy Medical Services, and my question was answered. I was just wondering about how we get answers to some of the other questions that were being e-mailed, but you already addressed that. So thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from (Howard John).

(Howard John): Hi. I have a question about primary care setting. In a long-term care facility, particularly skilled nursing facilities and nursing facilities, primary care is delivered in two ways. Sometimes it's at bedside, and sometimes there may be a room down the hall, which may or may not be established as a physician office for modifier purposes. Is there any restriction against the services being provided at bedside when individuals are residing in facilities where they get all of their primary care?

Leah Nguyen: Can you hold on for one moment, please?

(Howard John): Sure.

Cynthia Thomas: Hi. These services cannot be performed in a skilled nursing setting. The studies are pretty much defined. You can only have them in the place of service 11, 22, 49, 50, 71, and 72, and there may be a couple extra for some of

the other ones. So if you're billing from a skilled nursing facility, it's not allowed.

(Howard John): But some facilities have a physician office onsite, so they could bill in that setting?

Cynthia Thomas: If that's how they do their normal billing – if they have a physician office onsite that they normally bill physician or place of service 11, yes, but if they're billing the skilled nursing facility as place of service, then no.

(Howard John): I question the policy but I understand the position.

Leah Nguyen: Alright. Thank you.

(Howard John): OK.

Operator: Your next question comes from Almoretta Faison.

Almoretta Faison: My question was already answered, but thank you.

Operator: Your next question comes from Linda Reynolds.

Linda Reynolds: Hi. I'm Linda Reynolds. I'm sure that this is probably a "no," but if you have a social worker in primary care, can they perform the depression screenings and the alcohol screening?

Leah Nguyen: Can you hold on for one moment, please?

Linda Reynolds: Sure.

Jamie Hermansen: We'll refer you back to the slides where we discussed primary care practitioners. Thank you.

Linda Reynolds: OK. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Charmaine Rhames.

Charmaine Rhames: Hi. This is Charmaine. My question was also answered. Thank you.

Operator: Your next question comes from Sharon Ford.

Sharon Ford: Hello.

Leah Nguyen: Hello.

Sharon Ford: Yes. My question was: For a provider-based physician's office, of course, we're going to bill place of service 22, but then there's also going to be a facility fee on a UB for the technical part. So is that going to make it count as two visits since it's being billed – split out and billed on both the 1500 and a UB with the same code?

Wil Gehne: No. It will not. The professional service and the facility fee are counted separately, so the two together will be counted as one.

Sharon Ford: And they will both process with no problem?

Wil Gehne: Yes, ma'am.

Sharon Ford: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Lydia Adam.

Female: Lydia Adam! Pick it up, guys. Pick it up. (Inaudible)

Lydia Adam: Hello?

Leah Nguyen: Hello.

Lydia Adam: Hi. This is Lydia Adam. I'm calling from the Central Billing Office. I have a question. We have been billing out these codes for the last several months, and my question is, when our physician provides an E&M code for a patient for a routine visit and decides to do a G0447 or 65 or the G0444 – do we need to add a 59 modifier to these – to the E&M code? The only time we have been adding a 59 modifier was when we were billing out the alcohol, the G0442, and the G0443.

Leah Nguyen: Hold on for one moment.

Hello. I think – I believe that question is already being submitted to the resource box, but if you want to send it in also to slide 105 – and again, we'll be preparing a list of Frequently Asked Questions for the call that we will e-mail to all the call registrants and send out on our listserv and also post on the call Web page.

Lydia Adam: OK. Because most people were asking about the alcohol, and we have been adding 59. They have been paying with an E&M code. I was worried more about the other CPT codes – for the cardiovascular, you know, the obesity, and the other – and the other ones, in particular – and the depression.

Leah Nguyen: OK. I would just recommend if you want to just e-mail the specific question to us, we're going to do a little bit of research, and we'll get answers out. We'll answer your question, and then we'll also have an FAQ document as well.

Lydia Adam: Thank you so much.

Leah Nguyen: You're welcome.

Operator: Your next question comes from Tammy Farris.

Tammy Farris: Hi. This is Tammy, and my question is: When these services are provided in a teaching facility under a primary care exception, does the primary care

exception apply to them? Meaning they, the TP, the teaching physician does not have to provide a face-to-face visit with the patient in order to bill when it has been performed by a resident.

Leah Nguyen: Can you hold on for a moment?

Hello. If you could submit that question to our resource box, again on slide 105. We'll look into that for you.

Tammy Farris: On slide 105 are the instructions on how to do that?

Leah Nguyen: Yes. Yes. You could just e-mail your questions to us. We'll look into it and we'll get back to you on that.

Tammy Farris: OK. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Alex Czira.

Alex Czira: Hi. My name is Alex Czira, a primary care physician. My question is whether any of these wellness or preventive care visits can be performed in an assisted residential facility where the patients are independent, it's just – they have difficulty coming to the office.

Cynthia Thomas: They can only be performed in the place of services listed. So if it is not those place of services – and I believe we went over those – which were11, 22, 49, 71, and I think 72, I'm not sure – it cannot be performed, even in a assisted-living situation.

Alex Czira: Yes. OK.

Cynthia Thomas: To the doctors, the place of service 11 – that's different.

Alex Czira: OK. So they have to make that visit to the office.

Cynthia Thomas: Yes.

Alex Czira: OK. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Hazel Miller.

Hazel Miller: Yes. This is Hazel Miller, and I'm actually from a payer, and I have a question concerning the UB04 and the 1500 coming in with the same service. I heard the answer to be that you could get a UBN for the same date of service as the 1500, the professional, and both services would be covered, but wouldn't that really count as two services?

Wil Gehne: No, it would not, because one of them is billing for the professional service, and the other is the facility fee associated with that service. So we keep separate accounts, and we enforce the frequency limitations for the professional service and for the facility fee separately.

Hazel Miller: So are you saying that there is a facility annual screening and a professional annual screening, not one annual screening per calendar year?

Wil Gehne: There's one screening, but the practitioner can submit one claim for their professional service, and the facility where they perform that service can submit a separate claim for the facility fee. It's still one service, it's just paid in two different components – the two components – I'm sorry – can be paid on separate claims.

Leah Nguyen: Thank you. Brooke, it looks like we have time for one final question.

Operator: OK. Our last question comes from Judy Hood.

Judy Hood: Hi. This is Judy with Northwest Health Services. These codes state that deductible and co-insurance doesn't apply, but if patients have one of the commercial Medicare replacement plans, is it possible that they would have a co-pay or co-insurance or deductible?

Leah Nguyen: Hi. Thank you. If you go ahead and submit that question to our resource box on slide 105, we'll appreciate it.

Judy Hood: OK. Thank you.

Additional Information

Leah Nguyen: Thank you.

Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can e-mail it to preventionnpc@cms.hhs.gov, which is also listed on slide 105 of today's presentation. In the subject of your message, please include the name of the service and the slide number relating to your question. And again, we will be preparing a question and answer document of all the Frequently Asked Questions from the call, which we'll be sending out to call registrants, and also on our listserv, as well as sending individual answers to the questions that you submit.

I would like to thank everyone for participating in this National Provider Call on the New Medicare Preventive Services. On slide 106 of the presentation, you'll find information and a URL to evaluate your experience with today's call. Evaluations are anonymous and strictly confidential.

I should also point out that all registrants of today's call will receive a reminder e-mail from the CMS National Provider Calls Resource Box regarding the opportunity to evaluate this call. You may disregard this e-mail if you have already completed the evaluation. We appreciate your feedback.

An audio recording and written transcript of today's call will be posted soon to the CMS Fee-for-Service National Provider Calls Web page.

Again, my name is Leah Nguyen, and it's been my pleasure serving as your moderator today. I would like to thank our presenters – Michelle Issa, Jamie Hermansen, Deirdre O'Connor, Kathy Bryant, and Wil Gehne for their participation. Have a great day, everyone.

Operator: Thank you. This concludes the conference. You may now disconnect.

END