

**Centers for Medicare & Medicaid Services
Medicare Preventive Services National Provider Call:
Five New Medicare Preventive Services
Moderator: Leah Nguyen
August 15, 2012
2:00 p.m. ET**

Podcast 1 of 5: Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

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Introduction

Amanda Barnes: Welcome to the first of five podcasts from the New Medicare Preventive Services National Provider Call, brought to you by the Medicare Learning Network — your source for official CMS information for Medicare Fee-For-Service providers. This educational call was hosted by the CMS Provider Communications Group within the Center for Medicare on Wednesday, August 15, 2012.

In this first podcast, Michelle Issa from the Center for Clinical Standards & Quality, Kathy Bryant from the Hospital and Ambulatory Policy Group, and Wil Gehne from the Provider Billing Group discuss Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse.

Leah Nguyen: 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 1

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 OPPOS 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 deductible, 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 the 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.

Amanda Barnes: Thank you for listening to this Medicare Preventive Services educational podcast. The information in this podcast was correct as of the date it was recorded. This podcast is not a legal document. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings.

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