Medicare Preventive Services National Provider Call: New Medicare Preventive Services

August 15, 2012

Medicare PREVENTIVE SERVICES

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Agenda

- Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse
- Screening for Depression in Adults
- Intensive Behavioral Therapy for Cardiovascular Disease
- Screening for Sexually Transmitted Infections and High-Intensity Behavioral Counseling to prevent STIs
- Intensive Behavioral Therapy for Obesity
- General Preventive Services Resources
- Continuing Education Information
- Question and Answer Session
- Evaluate Your NPC Experience

Presenters

Michelle Issa, Jamie Hermansen & Deirdre O'Connor Coverage & Analysis Group (CAG) Center for Clinical Standards & Quality (CCSQ)
Kathy Bryant Hospital Ambulatory Policy Group (HAPG) Center for Medicare (CM)
Wil Gehne Provider Billing Group (PBG) Center for Medicare (CM)

Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

Effective 10/14/11

Michelle Issa

Description of Service

- Effective October 14, 2011, Medicare will cover annual alcohol screening, and for those that screen positive, Medicare covers up to 4, brief, face-to-face behavioral counseling interventions annually for Medicare beneficiaries, including pregnant women.

Michelle Issa

Description of Service & Beneficiary Eligibility

- For those beneficiaries who screen positive, Medicare covers up to 4 brief 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

Michelle Issa

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 qualified primary care physicians, or other primary care practitioners in a primary care setting.

Michelle Issa

Description of Primary Care Practitioner

- Primary care practitioner
  - Physician with specialty designation of general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist
  - Physician assistant
  - Nurse practitioner
  - Clinical nurse specialist

HCPCS Codes G0442 & G0443

Kathy Bryant

G0442

Annual, alcohol misuse screening, 15 minutes

- National Payment Rates
  - $17.36 Physician (non-facility)
  - $9.19 Physician (facility)
  - $35.69 Hospital/Outpatient
- No beneficiary co-insurance/deductible

G0443

Brief, face-to-face behavioral counseling sessions, 15 minutes

- National Payment Rates
  - $25.19 Physician (non-facility)
  - $23.15 Physician (facility)
  - $35.69 Hospital/Outpatient
- No beneficiary co-insurance/deductible

Medicare Physician Fee Schedule Search Tool

Kathy Bryant

- Medicare Physician Fee Schedule Search Tool
- Includes payment rates
  - National and by individual carriers
  - Limiting charge
  - Payment policy indicators
  - Short descriptor
  - Can look up by code, range of codes or list of codes
  - Updated at least quarterly

Kathy Bryant

HCPCS CODE	MODIFIER	SHORT DESCRIPTION	PROC STAT	CARRIER LOCALITY	NON-FACILITY PRICE	FACILITY PRICE	NON-FACILITY LIMITING CHARGE	FACILITY LIMITING CHARGE	CONV FACT	NA FLAG FOR TRANS NON-FAC PE RVU	NA FLG FOR FULLY IMP NON-FAC PE RVU	NA FLAG FOR TRANS FACILITY PE RVU	NA FLAG FOR FULLY IMP FAC PE RVU	NOT USED FOR MEDICARE	OPPS NON-FACILITY PAYMENT AMOUNT[1]	OPPS FACILITY PAYMENT AMOUNT[1]
G0442		Annual alcohol screen 15 min	A	0000000	$17.36	$9.19	$18.96	$10.04	34.0376						NA	NA
G0443		Brief alcohol misuse counsel	A	0000000	$25.19	$23.15	$27.52	$25.29	34.0376						NA	NA
G0444		Depression screen annual	A	0000000	$17.36	$9.19	$18.96	$10.04	34.0376						NA	NA
G0445		High inten beh couns STD 30m	A	0000000	$25.19	$23.15	$27.52	$25.29	34.0376						NA	NA
G0446		Intens behave ther cardio dx	A	0000000	$25.19	$23.15	$27.52	$25.29	34.0376						NA	NA

Coding Professional Claims

- HCPCS Code G0442
- HCPCS Code G0443
- Provider Specialty Types

01	General Practice
08	Family Practice
11	Internal Medicine
16	Obstetrics/Gynecology
37	Pediatric Medicine
38	Geriatric Medicine
42	Certified Nurse Midwife
50	Nurse Practitioner
89	Certified Clinical Nurse Specialist
97	Physician Assistant

Wil Gehne

Place of Service Codes

11	Physician's Office
22	Outpatient Hospital
49	Independent Clinic
50	Federally Qualified Health Center
71	State or local public health clinic
72	Rural health clinic

Wil Gehne

Medicare System Edits – Professional Claims

- To ensure claim lines with G0442 and G0443 are denied if billed without the appropriate place of service code
- Remittance advice coding for denials
  - Claim Adjustment Reason Code (CARC) 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service—Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
  - Remittance Advice Remark Code (RARC) N428: Service/procedure not covered when performed in certain settings

Wil Gehne

Medicare System Edits – Professional Claims

Wil Gehne

- To ensure G0442 and G0443 are billed by allowed specialty providers
- Remittance advice coding for denials
  - CARC 185: The rendering provider is not eligible to perform this service billed—Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
  - RARC N95: This provider type/provider specialty may not bill this service

Coding Institutional Claims

- HCPCS Code G0442
- HCPCS Code G0443
- Types of Bill:

Facility Type	Type of Bill
Hospital Outpatient	13X
Rural Health Clinic (RHC)	71X
Federally Qualified Health Center (FQHC)	77X
Critical Access Hospital (CAH)	85X

Wil Gehne

Medicare System Edits – Institutional Claims

Wil Gehne

- To ensure G0442 and G0443 are billed by allowed types of bill
- Remittance advice coding for denials
  - CARC 5: The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
  - RARC M77: Missing/incomplete/invalid place of service

Basis of Payment Varies by Institutional Facility Type

Facility Type	Basis of Payment
Hospital Outpatient	Outpatient Prospective Payment System (OPPS)
RHC	All-Inclusive Payment Rate
FQHC	All-Inclusive Payment Rate
CAH	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services

Wil Gehne

Special Instructions for RHC/FQHC

- Alcohol screening or counseling is usually not separately payable with another encounter/visit on the same date
  - A separate service line is reported. Medicare systems bundle the line with the encounter, shown on the remittance advice with CARC 97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- Exceptions:
  - Initial Preventive Physical Exam claims (Welcome to Medicare Visit - HCPCS G0402)
  - Claims containing modifier 59 (distinct procedural service)
  - FQHC (77X) claims containing DSMT & MNT services

Wil Gehne

Professional Service and Facility Fee

Wil Gehne

- Professional Services
  - Any professional claim
  - Institutional claims with Types of Bill 71x and 77x or
  - Type of Bill 85x with professional service revenue codes (096x, 097x, or 098x)
- Facility Fees
  - Type of Bill 13x
  - Type of Bill 85x when professional service revenue codes (096x, 097x, or 098x) are not reported

Medicare System Edits – All Claims

Wil Gehne

- To ensure G0442 is not billed more than once in a 12-month period and G0443 is not billed more than 4 times in a 12-month period
- Remittance advice coding for denials
  - CARC 119: Benefit maximum for this period or occurrence has been reached
  - RARC N362: The number of days or units of service exceeds our acceptable maximum
- Professional Service and Facility Fee can be billed separately

Medicare System Edits – All Claims

Wil Gehne

- To ensure G0443 is not billed more than once on the same date of service for the same beneficiary
- Remittance advice coding for denials
  - CARC 151: Payment adjusted because the payer deems the information submitted does not support this many/frequency of services
  - CARC M86: Service denied because payment already made for same/similar procedure within set time frame

Medicare System Edits – All Claims

- To ensure, the screening code, G0442 is in a beneficiary's history before claims with G0443 can be paid
- Remittance advice coding for denials
  - CARC B15: This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated— Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
  - RARC M16 – Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision

Wil Gehne

Need More Information?
Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

More Information

Medicare Learning Network® MLN Booklet

MLN Matters® Article

National Coverage Determination

Decision Memo

Medicare Physician Fee Schedule Search Tool

CY 2013 Physician Fee Schedule Proposed Rule

Screening for Depression in Adults
Effective 10/14/11

Michelle Issa

Description of Service

- 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 follow-up.

Michelle Issa

Description of Service

- Screening up to 15 minutes for depression screening for Medicare beneficiaries in a primary care settings when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up
- At a minimum level, staff-assisted supports consist of clinical staff (e.g., nurse, 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

Michelle Issa

Description of Service

- 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

Michelle Issa

Coverage Limitations

- Screening for depression is non-covered when performed more than one time in a 12-month period
- 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

HCPCS Code G0444

Kathy Bryant

Annual, depression screening, 15 minutes

- National Payment Rates
  - $17.36 Physician (non-facility)
  - $9.19 Physician (facility)
  - $35.69 Hospital/Outpatient
- No beneficiary co-insurance/deductible

Coding Professional Claims

- HCPCS Code G0444
- Place of Service Codes

11	Physician's Office
22	Outpatient Hospital
49	Independent Clinic
71	State or local public health clinic

Wil Gehne

Medicare System Edits – Professional Claims

Wil Gehne

- To ensure G0444 services are provided in the correct place of service.
- Remittance advice coding for denials
  - CARC 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF), if present.”
  - RARC N428: “Not Covered when performed in this place of service.”

Coding Institutional Claims

- HCPCS Code G0444
- Types of Bill:

Facility Type	Type of Bill
Hospital Outpatient	13X
Rural Health Clinic (RHC)	71X
Federally Qualified Health Center (FQHC)	77X
Critical Access Hospital (CAH)	85X

Wil Gehne

Medicare System Edits – Institutional Claims

Wil Gehne

- To ensure G0444 is billed by allowed types of bill
- Remittance advice coding for denials
  - CARC 170: Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
  - RARC N428: Not covered when performed in this place of service

Basis of Payment Varies by Institutional Facility Type

Facility Type	Basis of Payment
Hospital Outpatient*	Outpatient Prospective Payment System (OPPS)
RHC	All-Inclusive Payment Rate
FQHC	All-Inclusive Payment Rate
CAH	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services

- Special instructions for RHC/FQHC apply – see slide 21

Wil Gehne

Frequency for Annual Depression Screening

- Annual depression screening, G0444, no more than once in a 12-month period
  - Note: 11 full months must elapse following the month in which the last annual depression screening took place

Wil Gehne

Medicare System Edits – All Claims

Wil Gehne

- To ensure G0444 is billed only once in a 12-month period.
- Remittance advice coding for denials
  - CARC 119: “Benefit maximum for this time period or occurrence has been reached.”
  - RARC N362: “The number of days or units of service exceeds our acceptable maximum.”
- Professional Service and Facility Fee can be billed separately
  - As defined on slide 22

Need More Information?
Screening for Depression in Adults

More Information

Medicare Learning Network® MLN Booklet

MLN Matters® Article

National Coverage Determination

Decision Memo

Medicare Physician Fee Schedule Search Tool

CY 2013 Physician Fee Schedule Proposed Rule

Intensive Behavioral Therapy for Cardiovascular Disease

Effective 11/8/11

Jamie Hermansen

Description of Service & Frequency

- IBT for Cardiovascular Disease (a CVD risk reduction visit)
- The visit consists of the following 3 components
  - Encouraging aspirin use for primary prevention of cardiovascular disease
  - Screening for high blood pressure
  - Intensive behavioral counseling to promote healthy diet
- 1 face-to-face CVD risk reduction visit each year

Jamie Hermansen

Who is Covered and Who can Furnish the Service?

- Medicare beneficiaries
  - Competent and alert at time counseling is provided
- Furnished by a qualified primary care physician or other primary care practitioner in a primary care setting

Jamie Hermansen

Description of Primary Care Practitioner

- Primary care practitioner:
  - Physician with specialty designation of general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist
  - Physician assistant
  - Nurse practitioner
  - Clinical nurse specialist

Jamie Hermansen

Description of Primary Care Setting

- 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 context of family and community

HCPCS Code GO446

Kathy Bryant

- Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, bi-annual, 15 minutes
- National Payment Rates
  - $25.19 Physician (non-facility)
  - $23.15 Physician (facility)
  - $35.69 Hospital/Outpatient
- No beneficiary co-insurance/deductible

Coding Professional Claims

- HCPCS Code G0446
- Provider Specialty Types

01	General Practice
08	Family Practice
11	Internal Medicine
16	Obstetrics/Gynecology
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Certified Clinical Nurse Specialist
97	Physician Assistant

Wil Gehne

Place of Service Codes

11	Physician's Office
22	Outpatient Hospital
49	Independent Clinic
71	State or local public health clinic

Wil Gehne

Medicare System Edits – Professional Claims

- To ensure G0446 is billed with the allowable provider specialty types
- Remittance advice coding for denials
  - CARC 185: The rendering provider is not eligible to perform the service billed
  - RARC N95: This provider type/provider specialty may not bill this service
- To ensure G0446 is billed with the allowable place of service
- Remittance advice coding for denials
  - CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service
  - RARC N428: Not covered when performed in this place of service

Wil Gehne

Coding Institutional Claims

Wil Gehne

- HCPCS Code G0446
- Types of Bill:

Facility Type	Type of Bill
Hospital Outpatient	13X
Rural Health Clinic (RHC)	71X
Federally Qualified Health Center (FQHC)	77X
Critical Access Hospital (CAH)	85X

Medicare System Edits – Institutional Claims

Wil Gehne

- To ensure G0446 is billed by allowed types of bill
- Remittance advice coding for denials
  - CARC 170: Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
  - RARC N428: Not covered when performed in this place of service

Basis of Payment Varies by Institutional Facility Type

Facility Type	Basis of Payment
Hospital Outpatient*	Outpatient Prospective Payment System (OPPS)
RHC	All-Inclusive Payment Rate
FQHC	All-Inclusive Payment Rate
CAH	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services

- Special instructions for RHC/FQHC apply – see slide 21

Wil Gehne

Medicare System Edits – All Claims

- To ensure G0446 is billed no more than once in a 12 month period
  - Note: 11 full months must elapse following the month in which the last screening took place
- Remittance advice coding for denials
  - CARC 119: Benefit maximum for this time period or occurrence has been reached
  - RARC N362: The number of days or units of service exceeds our acceptable maximum
- Professional Service and Facility Fee can be billed separately
  - As defined on slide 22

Wil Gehne

Need More Information?
Intensive Behavioral Therapy for Cardiovascular Disease

More Information

MLN Matters® Article

National Coverage Determination

Decision Memo

Medicare Physician Fee Schedule Search Tool

CY 2013 Physician Fee Schedule Proposed Rule

Screening for Sexually Transmitted Infections and High-Intensity Behavioral Counseling to prevent STIs

Effective 11/8/11

Deirdre O'Connor

Description of Service

- Effective for dates of service on or after November 8, 2011, CMS will cover screening for Sexually Transmitted Infections (STIs) - specifically Chlamydia, gonorrhea, syphilis, and hepatitis B - with the appropriate Food and Drug Administration (FDA) 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 (CLIA) regulations and performed by an eligible Medicare provider for these services

Deirdre O'Connor

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
- Women at increased risk for STIs annually

Deirdre O'Connor

Who is Covered and Frequency:
Screening 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 test
- Men and women at increased risk for STIs annually

Deirdre O'Connor

Who is Covered and Frequency:
Screening 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

Deirdre O'Connor

Coverage Policy for High Intensity Behavioral Counseling

- 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 (HIBC) 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

Deirdre O'Connor

Description of Primary Care Practitioner

- Primary care practitioner:
  - Physician with specialty designation of general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist
  - Physician assistant
  - Nurse practitioner
  - Clinical nurse specialist

Deirdre O'Connor

Description of Primary Care Setting

- 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 context of family and community

Deirdre O'Connor

High Intensity Behavioral Counseling

- HIBC 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
  - Guidance on how to change sexual behavior
- The medical record should be a reflection of the service provided
- See the MLN Matters article or National Coverage Determination (NCD) on slide 80 for a complete description of who is considered high/increased risk

Deirdre O'Connor

Who is Covered and Frequency:
High Intensity Behavioral Counseling

- 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

HCPCS Code G0445

Kathy Bryant

- High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes
- National Payment Rates
  - $25.19 Physician (non-facility)
  - $23.15 Physician (facility)
  - $35.69 Hospital/Outpatient
- No beneficiary co-insurance/deductible

Lab Tests

Kathy Bryant

Also covers clinical laboratory tests for

- Chlamydia
- Gonorrhea
- Syphilis
- Hepatitis B

Clinical Laboratory Fee Schedule

For more information, contact anne-e-tayloe.hauswald@cms.hhs.gov

Coding Professional Claims

- HCPCS Code G0445
- ICD-9-CM Diagnosis Code –screening, bacterial-sexually transmitted (V69.8) other problems related to lifestyle
- Provider Specialty Types

01	General Practice
08	Family Practice
11	Internal Medicine
16	Obstetrics/Gynecology
37	Pediatric Medicine
38	Geriatric Medicine
42	Certified Nurse Midwife
50	Nurse Practitioner
89	Certified Clinical Nurse Specialist
97	Physician Assistant

Wil Gehne

Place of Service Codes

11	Physician's Office
22	Outpatient Hospital
49	Independent Clinic
71	State or local public health clinic

Wil Gehne

Medicare System Edits – Professional Claims

- To ensure G0445 is billed with the allowable provider specialty types
- Remittance advice coding for denials
  - CARC 185: The rendering provider is not eligible to perform the service billed
  - RARC N95: This provider type/provider specialty may not bill this service
- To ensure G0445 is billed with the allowable place of service
- Remittance advice coding for denials
  - CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service
  - RARC N428: Not covered when performed in this place of service

Wil Gehne

Coding Institutional Claims

- HCPCS Code G0445
- ICD-9-CM Diagnosis Code –screening, bacterial-sexually transmitted (V69.8) other problems related to lifestyle
- Institutional Types of Bill

Wil Gehne

Facility Type	Type of Bill
Hospital Outpatient	13X
Rural Health Clinic (RHC)	71X
Federally Qualified Health Center (FQHC)	77X
Critical Access Hospital (CAH)	85X

Medicare System Edits – Institutional Claims

Wil Gehne

- To ensure G0445 is billed by allowed types of bill
- Remittance advice coding for denials
  - CARC 170: Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
  - RARC N428: Not covered when performed in this place of service

Basis of Payment Varies by Institutional Facility Type

Facility Type	Basis of Payment
Hospital Outpatient*	Outpatient Prospective Payment System (OPPS)
RHC	All-Inclusive Payment Rate
FQHC	All-Inclusive Payment Rate
CAH	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services

- Special instructions for RHC/FQHC apply – see slide 21

Wil Gehne

Medicare System Edits – All Claims

Wil Gehne

- To ensure G0445 is billed with diagnosis codes V69.8
- Remittance advice coding for denials
  - CARC 50: These are non-covered services because this is not deemed a 'medical necessity' by the payer—Note: Refer to the 835 Healthcare Policy identification Segment (loop 2110 Service Payment information REF), if present
  - RARC N386: This decision was based on an NCD

Medicare System Edits – All Claims

Wil Gehne

- To ensure G0445 is billed no more than 2 sessions in a 12 month period
- Remittance advice coding for denials
  - CARC 119: Benefit maximum for this time period or occurrence has been reached
  - RARC N362: The number of days or units of service exceeds our acceptable maximum
- Professional Service and Facility Fee can be billed separately
  - As defined on slide 22

Coding Professional Claims — Laboratory Billing

Wil Gehne

HCPCS Codes for STI Lab tests:

- Chlamydia: 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800 (used for combined Chlamydia and gonorrhea testing)
- Gonorrhea: 87590, 87591, 87850, 87800 (used for combined Chlamydia and gonorrhea testing)
- Syphilis: 86592, 86593, 86780
- Hepatitis B: (hepatitis B surface antigen): 87340, 87341

ICD-9-CM Diagnosis Codes

- V74.5 - Screening, bacterial-sexually transmitted
- V73.89 – Screening, disease or disorder, viral, specified type NEC
- V69.8 – Other problems related to life style
- V22.0, V22.1 or V23.9 – Pregnancy diagnosis codes

Valid Ordering Provider Specialties — Laboratory Billing

01	General Practice
08	Family Practice
11	Internal Medicine
16	Obstetrics/Gynecology
37	Pediatric Medicine
38	Geriatric Medicine
42	Certified Nurse Midwife
50	Nurse Practitioner
89	Certified Clinical Nurse Specialist
97	Physician Assistant

Wil Gehne

Medicare System Edits — Laboratory Billing

Wil Gehne

- To ensure screenings for STIs are billed with the appropriate ICD-9 diagnosis codes
- Remittance advice coding for denials
  - Claim Adjustment Reason Code (CARC) 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy identification Segment (loop 2110 Service Payment information REF), if present.
  - Remittance Advice Remark Code (RARC) N386 – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD

Medicare System Edits — Laboratory Billing

Wil Gehne

- To ensure the ordering physician specialty is appropriate for screenings for STIs
- Remittance advice coding for denials
  - CARC 184 – The prescribing/ordering provider is not eligible to prescribe/order the service billed. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present

Medicare System Edits — Laboratory Billing

Wil Gehne

- To ensure billed screenings for STIs do not exceed coverage frequency limitations. Coverage frequency differs based on the test performed, patient gender, high risk diagnosis, and pregnancy status.
- Remittance advice coding for denials
  - CARC 119 – Benefit maximum for this period or occurrence has been reached.
  - RARC N362 – The number of days or units of service exceeds our acceptable maximum.

Need More Information?
Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to prevent STIs

More Information

MLN Matters® Article

National Coverage Determination

Decision Memo

Medicare Physician Fee Schedule Search Tool

CY 2013 Physician Fee Schedule Proposed Rule

Intensive Behavioral Therapy for Obesity

Effective 11/29/11

Jamie Hermansen

Description of Service

- Effective November 29, 2011, Medicare covers intensive behavioral therapy for obesity for beneficiaries with a body mass index (BMI) ≥ 30 kg/m^2
- Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m^2)
- Dietary (nutritional) assessment
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise

Jamie Hermansen

What is the Counseling Schedule for Eligible Beneficiaries?

- 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 2-6
  - One face-to-face visit every month for months 7-12, if the beneficiary loses 3kg during the first six months

Jamie Hermansen

What if a Beneficiary Does Not Lose 3kg During the First Six Months of Counseling?

- A reassessment of obesity and determination of the amount of weight loss must be performed for each beneficiary at the six month visit
- Beneficiaries must lose 3kg during the first six months of counseling to be eligible for counseling for another six months
- Beneficiaries who do not achieve a weight loss of 3kg or more may undergo reassessment of their readiness to change and BMI after an additional six month period

Jamie Hermansen

Where Can Eligible Beneficiaries Receive These Services and Who Can Provide Them?

- Intensive behavioral therapy for obesity must be furnished in a primary care setting by a primary care practitioner

Jamie Hermansen

Description of Primary Care Practitioner

- Primary care practitioner:
  - Physician with specialty designation of general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist
  - Physician assistant
  - Nurse practitioner
  - Clinical nurse specialist

Jamie Hermansen

Description of Primary Care Setting

- 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 context of family and community

Jamie Hermansen

Can Anyone Other Than Primary Care Providers Furnish These Services?

- This 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 (NCD) 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) (conditions for services and supplies incident to a physician's professional service). 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 NCD Manual.

Jamie Hermansen

Can Anyone Other Than Primary Care Providers Furnish These Services?—Continued

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 (conditions for outpatient hospital services and supplies incident to a physician service). 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.

HCPCS Code G0447

Kathy Bryant

Face-to-face behavioral counseling for obesity, 15 minutes

- National Payment Rates
  - $25.19 Physician (non-facility)
  - $23.15 Physician (facility)
  - $35.69 Hospital/Outpatient
- No beneficiary co-insurance/deductible

Coding Professional Claims

- HCPCS Code G0447
- ICD-9-CM Diagnosis Code indicating BMI over 30 (V85.30 – 39, V85.41-45)
- Provider Specialty Types

01	General Practice
08	Family Practice
11	Internal Medicine
16	Obstetrics/Gynecology
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Certified Clinical Nurse Specialist
97	Physician Assistant

Wil Gehne

Place of Service Codes

11	Physician's Office
22	Outpatient Hospital
49	Independent Clinic
71	State or local public health clinic

Wil Gehne

Medicare System Edits – Professional Claims

Wil Gehne

- To ensure G0447 is billed with the allowable provider specialty types
- Remittance advice coding for denials
  - CARC 185: The rendering provider is not eligible to perform the service billed
  - RARC N95: This provider type/provider specialty may not bill this service

Medicare System Edits – Professional Claims

Wil Gehne

- To ensure G0447 is billed with the allowable place of service
- Remittance advice coding for denials
  - CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service
  - RARC N428: Not covered when performed in this place of service

Coding Institutional Claims

- HCPCS Code G0447
- ICD-9-CM Diagnosis Code indicating BMI over 30 (V85.30 – 39, V85.41-45)
- Types of Bill:

Facility Type	Type of Bill
Hospital Outpatient	13X
Rural Health Clinic (RHC)	71X
Federally Qualified Health Center (FQHC)	77X
Critical Access Hospital (CAH)	85X

Wil Gehne

Medicare System Edits – Institutional Claims

Wil Gehne

- To ensure G0447 is billed by allowed types of bill
- Remittance advice coding for denials
  - CARC 5: The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
  - RARC M77: Missing/incomplete/invalid place of service

Basis of Payment Varies by Institutional Facility Type

Facility Type	Basis of Payment
Hospital Outpatient*	Outpatient Prospective Payment System (OPPS)
RHC	All-Inclusive Payment Rate
FQHC	All-Inclusive Payment Rate
CAH	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services

- Special instructions for RHC/FQHC apply – see slide 21

Wil Gehne

Medicare System Edits – All Claims

Wil Gehne

- To ensure G0447 is billed with one of the specified diagnosis codes
- Remittance advice coding for denials
  - CARC 167: This (these) diagnosis(es) is (are) not covered
  - RARC N386: This decision was based on an NCD

Medicare System Edits – All Claims

Wil Gehne

- To ensure G0447 is billed no more than 22 times in a 12 month period
- Remittance advice coding for denials
  - CARC 119: Benefit maximum for this time period or occurrence has been reached
  - RARC N362: The number of days or units of service exceeds our acceptable maximum
- Professional Service and Facility Fee can be billed separately
  - As defined on slide 22
- Other information: Next eligible dates for all the services described above will be viewable through all standard inquiry methods

Need More Information?
Intensive Behavioral Therapy for Obesity

More Information

Medicare Learning Network® MLN Booklet

MLN Matters® Article

National Coverage Determination

Decision Memo

Medicare Physician Fee Schedule Search Tool

CY 2013 Physician Fee Schedule Proposed Rule

How to Submit Comments for the CY 2013 Physician Fee Schedule Proposed Rule

CY 2013 Physician Fee Schedule Proposed Rule

- Publication Date: July 30, 2012
- Public Comment Period: CMS will accept comments on the proposed rule until September 04, 2012, and will respond to them in a final rule with comment period to be issued by November 1, 2012.
- You may submit comments in one of four ways. See the Proposed Rule for complete details:
  - Electronically
  - By regular mail
  - By express or overnight mail
  - By hand or courier

General Preventive Services Resources

Learn More About Medicare-Covered Preventive Services

The Guide to Medicare Preventive Services

MLN Products Preventive Services Web Page

CMS Prevention Website

Continuing Education Information

- Continuing education credits may be awarded by the American Academy of Professional Coders (AAPC), the American Health Information Management Association (AHIMA), and the American Medical Billing Association (AMBA) for participation in certain CMS National Provider Calls
- Visit the FFS National Provider Calls Continuing Education Credit Notification webpage at http://www.cms.gov/NPC/20_CEC_Notification.asp for more details.

Q & A

In the interest of time, please limit your question to one so that we may hear from as many participants as possible.

You may enter *1 to re-enter the queue and we will address follow-up questions as time permits.

Thank you for your cooperation.

Questions?

Email your questions to
PreventionNPC@cms.hhs.gov

Evaluate Your Experience with Today's National Provider Call

To ensure that the National Provider Call (NPC) Program continues to be responsive to your needs, we are providing an opportunity for you to evaluate your experience with today's NPC. Evaluations are anonymous and strictly voluntary.

To complete the evaluation, visit http://npc.blhtech.com/ and select the title for today's call from the menu.

All registrants will also receive a reminder email within two business days of the call. Please disregard this email if you have already completed the evaluation.

We appreciate your feedback!

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