

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – On November 17, 2011, the Centers for Medicare & Medicaid Services' Office of E-Health Standards and Services (OESS) announced that it would not initiate enforcement with respect to any HIPAA covered entity that is not in compliance on January 1, 2012 with the ASC X12 Version 5010 (Version 5010), NCPDP Telecom D.0 (NCPDP D.0) and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards until March 31, 2012. Notwithstanding OESS' discretionary application of its enforcement authority, the compliance date for use of these new standards remains January 1, 2012 (small health plans have until January 1, 2013 to comply with NCPDP 3.0).

MLN Matters® Number: MM7636 **Revised**

Related Change Request (CR) #: 7636

Related CR Release Date: March 23, 2012

Effective Date: November 8, 2011

Related CR Transmittal #: R137NCD and R2432CP

Implementation Dates: December 27 for local Medicare Contractor system edits; April 2, 2012, for Medicare shared system edits; and July 2, 2012, CWF provider screens and HICR changes

Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD)

Note: This article was revised on March 27, 2012, to reflect the revised CR7636 issued on March 23, 2012. As a result, in this article, the CR release date, transmittal number, and the web address for accessing CR7637 have been revised. Also, the article reflects the addition of CARC 50 on the remittance replies on claims line items submitted with the GZ modifier. All other information is the same.

Provider Types Affected

Primary care practitioners in a primary care setting such as the beneficiary's family practice physician, internal medicine physician, or Nurse Practitioner in the doctor's office who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), or Medicare Administrative Contractors (A/B MACs)) for providing Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD) to Medicare beneficiaries.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

Provider Action Needed

This article is based on Change Request (CR) 7636 which states that effective for claims with dates of service on and after November 8, 2011, the Centers for Medicare & Medicaid Services (CMS) covers IBT for CVD, inclusive of one face-to-face **CVD risk reduction visit** annually. The Medicare patient receiving this care must be competent and alert at the time the service is rendered and the service must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. Ensure that your billing staffs are aware of this update.

Background

According to Section 1861 of the Social Security Act, CMS may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process. The preventive services must meet all of the following criteria:

- (1) Reasonable and necessary for the prevention or early detection of illness or disability;
- (2) Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
- (3) Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the USPSTF recommendations and supporting evidence for IBT for CVD and determined that the criteria listed above was met, enabling CMS to cover this preventive service.

Coverage of IBT for CVD, referred to as a **CVD risk reduction visit**, consists of the following three components:

- (1) Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years;
- (2) Screening for high blood pressure in adults age 18 years and older; and,
- (3) Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease.

Key Points

- A new HCPCS code, G0446, **Annual, face-to-face IBT for CVD, individual, 15 minutes**, will be included in the January 2012 updates of the Medicare Physician Fee Schedule Database (MPFSDB) and Integrated Outpatient Code Editor (IOCE), effective for services on or after November 8, 2011.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

- Medicare deductibles and coinsurance do not apply to claim lines containing HCPCS code G0446.
- For these services provided on or after November 8, 2011, through December 31, 2011, Medicare contractors will apply their pricing to claims for G0446 when billed for IBT for CVD.
- Effective for claims with dates of service on and after November 8, 2011, CMS covers one face-to-face **CVD risk reduction visit annually** for Medicare beneficiaries 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 in a primary care setting.
- For the purposes of this covered service, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The following provider specialty types may submit claims for CVD risk reduction visits:
 - 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
- Medicare Contractors will pay claims for G0446 only when services are provided for the following Place of Service (POS):
 - 11-Physician's Office;
 - 22-Outpatient Hospital;
 - 49-Independent Clinic; or,
 - 71-State or local public health clinic.

Note: Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are **not considered primary care settings** under this definition. See below for information relative to these services billed on institutional claims by RHCs, Type of Bill (TOB) 71X, and FQHCs, TOB 77X.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

- The behavioral counseling intervention for aspirin use and healthy diet should be consistent with the Five As approach that has been adopted by the USPSTF to describe such services:
 - **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
 - **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
 - **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
 - **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
 - **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.
- Medicare contractors do not need to search their files for claims that may have been processed in error. However, contractors may adjust claims that are brought to their attention.

Claims Processing/Payment Information

When IBT for CVD claims are submitted with a POS code that is not applicable, they will be denied using:

- 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: "Not covered when performed in this place of service."
- Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed Advance Beneficiary Notice (ABN) is on file.
- Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed (ABN) is not on file. Also, per MLN Matters® Article MM7228 at

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

<http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.)

Medicare will deny claims for G0446 when provided by provider specialty types other than those identified above. When such claims are denied, Medicare will use the following messages:

- CARC 185: “The rendering provider is not eligible to perform the 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.”
- Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per MLN Matters® Article MM7228 at <http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.)

RHCs using TOB 71X and FQHCs using TOB 77X may submit additional revenue lines containing G0446 and Medicare will pay those lines based on the all-inclusive payment rate. However, Medicare will not pay G0446 separately with another encounter/visit on the same day billed on TOBs 71X or 77X. This does not apply, however, to claims with the Initial Preventive Physical Examination (IPPE) containing modifier 59 or to 77X claims containing Diabetes Self-Management Training or Medical Nutrition Training services. If G0446 is billed when an encounter/visit is billed with the same line item date of service, Medicare will assign:

- Group Code CO to the G0446 revenue line; and
- RARC 97: “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Institutional claims billed by hospital outpatient departments (TOB 13X) will be paid based on the outpatient prospective payment system. Those billed by Critical Access Hospitals (CAHs) on TOB 85X will be paid based on reasonable cost, except those G0446 services billed with revenue codes 096X, 097X, or 098X by Method II CAHs will receive 115% of the lesser of the fee schedule amount or submitted charge.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

Institutional claims submitted on TOBs other than 13X, 71X, 77X, or 85X will be denied using the following:

- 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."
- Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per MLN Matters® Article MM7228 at <http://www.cms.gov/MLN MattersArticles/downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

For claims processed on or after April 2, 2012, Medicare will allow payment for G0446 no more than once in a 12-month period. However, Medicare will allow both a claim for the professional service and, for TOB 13X and TOB 85X with a revenue code of 96X, 97X, or 98X, a claim for a facility fee. Claim lines for G0446 that exceed this limit will be denied using:

- CARC 119: "Benefit maximum for this time period or occurrence has been reached."
- RARC N362: "The number of days or units exceeds our acceptable maximum."
- Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per MLN Matters® Article MM7228 at <http://www.cms.gov/MLN MattersArticles/downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, and ELGH) will display a next eligibility date for this service.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

Additional Information

If you have questions, please contact your Medicare carrier, MAC, or FI at their toll-free number which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction, CR7636, was issued to your Medicare FI, carrier, or A/B MAC regarding this change via two transmittals. The first transmittal modifies the "National Coverage Determinations Manual" at

<http://www.cms.gov/Transmittals/downloads/R137NCD.pdf> on the CMS website.

The second transmittal at

<http://www.cms.gov/Transmittals/downloads/R2432CP.pdf> modifies the "Medicare Claims Processing Manual."

News Flash - It's Not too Late to Give and Get the Flu Vaccine. Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) also recommends that patients, healthcare workers and caregivers be vaccinated against the seasonal flu. **Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug.** For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit [2011-2012 Provider Seasonal Flu Resources](#) and [Immunizations](#). For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.