

Questions from National Medicare Training Program Update Call on January 17, 2012

1	<p>Some plans have copays on preventative services and Medicare does not. I thought Medicare Advantage plans were supposed to cover more services at less cost??</p>	<p>The Affordable Care Act provided original Medicare beneficiaries the right to coverage of certain preventive services with zero cost-sharing. Under regulations published on April 15, 2011, CMS used its authority to extend that right to beneficiaries enrolled in MA and cost plans. Thus, MAOs and cost plans are responsible for covering these preventive services with zero cost-sharing within network. To the extent that new preventive services are added to those covered under original Medicare with zero cost-sharing pursuant to the Affordable Care Act, MAOs and cost plans are responsible for covering such services with zero cost-sharing within network beginning on the applicable effective date. Further, MAOs and cost plans must ensure that claims for the items/services are paid retroactive to those dates.</p>
2	<p>There has been an Asthma State Taskforce created in Utah and I am the one responsible to coordinate with Medicare/Medicaid and try to make certain there is some sort of education path that people who suffer from Asthma can follow in Medicare and Medicaid. Are you aware of any such education/treatment available? If so where would I find this information and if not, who could I speak with to perhaps make this available to all of those people who suffer from this debilitating disease? Any assistance you could give me would be appreciated.</p>	<p>Each year, the Centers for Medicare & Medicaid Services (CMS) releases information about legislative changes and other changes in Medicare policy that, among other things, affect Medicare coverage, such as the opening of national coverage analyses (NCAs), posting of proposed and final coverage determinations, release of NCDs and accompanying instructions, etc.</p> <p>Generally, legislative changes to Medicare coverage rules are implemented through notice-and-comment rulemaking. If Medicare Part B coverage is affected, the changes are often included in the annual Medicare Physician Fee Schedule (MPFS) proposed and final rules. The MPFS proposed and final rules are published in the <i>Federal Register</i> every summer and fall, respectively. The corresponding Medicare manual guidance is released in either or both the Medicare Benefit Policy Manual Publication (Pub. 100-02) and Medicare Claims Processing Manual (Pub. 100-04).²</p> <p>Implementation of coverage changes resulting from the NCD process and of all changes to original Medicare claims processing are made through Change Requests (CRs) and Transmittals (TRs) that also are used to update the Medicare National Coverage Determinations Manual (Pub. 100-03) and the Medicare Claims Processing Manual (Pub. 100-04).²</p> <p>The average NCD process takes 9-12 months from the opening of the NCA to the final determination posted on the CMS Coverage Website.</p> <p>Physicians can monitor NCD changes through the Coverage Website, which also includes changes to the NCD Manual (Pub. 100-03). The NCD process, while lengthy, is also open and transparent and information is continually updated online on the CMS Website.</p> <p>To help physicians stay apprised of new and/or changing Medicare coverage policies that result from either legislation or the NCD process that may affect</p>

		<p>the Part A and B benefits, we provide a number of resource links, including a link to the CMS Coverage Website, below. The website includes all of the information necessary for physicians to track changes to Medicare Parts A and B coverage. In addition, we have provided a link for the “coverage listserv” and we encourage you to sign up for this listserv as another tool for tracking important coverage updates.</p> <p>Several helpful resources include:</p> <ul style="list-style-type: none"> • Coverage email updates page, sorted by year – https://www.cms.gov/CoverageGenInfo/EmailUpdates/list.asp#TopOfPage • Main Coverage Center page - https://www.cms.gov/center/coverage.asp • Sign-up for the coverage listserv - https://www.cms.gov/InfoExchange/03_listserv.asp#TopOfPage • Program Transmittals page - http://www.cms.gov/Transmittals/ 												
3	<p>Should the liability of a Medicare beneficiary who is denied coverage for a preventative examination--billed as 1.0 Per pm reeval est pat 65+ yr (99397)-- and who has not been given written notice in advance that the service will not be covered, be waived; and, if not, why not?</p>	<p>When a physician furnishes a Medicare beneficiary a covered visit at the same place and on the same occasion as a non-covered preventive medicine service (CPT codes 99381-99397), consider the covered visit to be provided in lieu of a part of the preventive medicine service of equal value to the visit. A preventive medicine service (CPT codes 99381-99397) is a non-covered service. The physician may charge the beneficiary, as a charge for the non-covered remainder of the service, the amount by which the physician’s current established charge for the preventive medicine service exceeds his/her current established charge for the covered visit. Pay for the covered visit based on the lesser of the fee schedule amount or the physician’s actual charge for the visit. The physician is not required to give the beneficiary written advance notice of non coverage of the part of the visit that constitutes a routine preventive visit. However, the physician is responsible for notifying the patient in advance of his/her liability for the charges for services that is not medically necessary to treat the illness or injury.</p>												
4	<p>By the way do we have the set of codes to use for Medicare in these New Preventive services? (Obesity, alcohol, depression screening?) I cannot find it in the website just articles.</p>	<p>Yes, here they are:</p> <table border="1" data-bbox="561 1402 1492 1751"> <tr> <td>G0442</td> <td>Annual alcohol misuse screening, 15 minutes</td> </tr> <tr> <td>G0443</td> <td>Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td> </tr> <tr> <td>G0444</td> <td>Annual Depression Screening, 15 minutes</td> </tr> <tr> <td>G0445</td> <td>High intensity behavioral counseling to prevent sexually transmitted education, skills training and guidance on how to change sexual behavior</td> </tr> <tr> <td>G0446</td> <td>Intensive behavioral therapy to reduce cardiovascular disease risk, 15 minutes</td> </tr> <tr> <td>G0447</td> <td>Face-to-face behavioral counseling for obesity, 15 minutes</td> </tr> </table> <p>For more information, click on the following link: http://www.cms.gov/MLN MattersArticles/downloads/MM7672.pdf</p>	G0442	Annual alcohol misuse screening, 15 minutes	G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	G0444	Annual Depression Screening, 15 minutes	G0445	High intensity behavioral counseling to prevent sexually transmitted education, skills training and guidance on how to change sexual behavior	G0446	Intensive behavioral therapy to reduce cardiovascular disease risk, 15 minutes	G0447	Face-to-face behavioral counseling for obesity, 15 minutes
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5	<p>I would like to know more information re: Part D coverage for the shingles vaccine.</p> <p>What if someone has a deductible?</p>	<p>Under the Tax Relief and Healthcare Act of 2006 (TRHCA), a “covered Part D drug” is defined to include the vaccine and the administration of the vaccine, this includes the shingles vaccine. For purposes of billing for vaccines, Part D vaccine administration therefore is unique. As defined by statute, the “drug” incorporates both the vaccine and its administration.</p> <p>Part D sponsors will allow any provider so authorized by State law to administer a Part D vaccine. Where it is safe to dispense and administer vaccines in a pharmacy, sponsors could explore utilization of their network pharmacists as providers of adult Medicare Part D vaccines (pediatric vaccines should continue to be provided by physicians). Out-of-network vaccines administered in a physician’s office or by other non-network providers may be covered under the out-of-network access rules, where a Part D enrollee may self-pay for the vaccine cost and its administration and submit a paper claim for reimbursement to his or her Part D sponsor.</p>
6	<p>Can you confirm that Medicare is now covering Screening/Counseling for STIs as part of their preventive services?</p>	<p>Effective for claims with dates of service on and after November 8, 2011, CMS will cover screening for Chlamydia, gonorrhea, syphilis, and hepatitis B with the appropriate FDA approved/cleared laboratory tests, used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the primary care provider, and performed by an eligible Medicare provider for these services. Also effective for claims with Dates of Service on and after November 8, 2011, CMS will cover up to two individual - 20 to 30 minute, face to face counseling sessions annually for Medicare beneficiaries for High Intensity Behavioral Counseling (HIBC) to prevent Sexually Transmitted Infections (STIs) for all sexually active adolescents and for adults at increased risk for 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.</p>
7	<p>If you have a colonoscopy & a polyp is found then removed is this then a surgery and not paid 100%?</p>	<p>In the course of performing a fiber optic colonoscopy (CPT code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon. The physician bills for codes 45380 and 45385. The value of codes 45380 and 45385 have the value of the diagnostic colonoscopy (45378) built in. Rather than paying 100 percent for the highest valued procedure (45385) and 50 percent for the next (45380), Medicare pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the base endoscopy (45378).</p> <p>Carriers assume the following fee schedule amounts for these codes: 45378 - \$255.40 45380 - \$285.98 45385 - \$374.56</p> <p>Medicare pay the full value of 45385 (\$374.56), plus the difference between 45380 and 45378 (\$30.58), for a total of \$405.14.</p>
9	<p>Could you please clarify the definition of primary care physician? My doctors are cardiologists and would like to be able to counsel their obese patients who make up at least 60% of their</p>	<p>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 Face-to-face behavioral counseling for obesity:</p> <ul style="list-style-type: none"> o 01-General Practice

	<p>patients. They are more than qualified in educating their patients as to lifestyle changes to better their quality of life as well as health. Also are these counseling sessions open to all Medicare enrolled patients or just first time preventive medicine patients? Thank you,</p>	<ul style="list-style-type: none"> o 08-Family Practice o 11-Internal Medicine o 16-Obstetrics/Gynecology o 37-Pediatric Medicine o 38-Geriatric Medicine o 42-Certified Nurse Midwife o 50-Nurse Practitioner o 89-Certified Clinical Nurse Specialist o 97-Physician Assistant <p>Counseling sessions are available for all Medicare patients who are screened and determined to be obese with a BMI $\geq 30 \text{ kg/m}^2$. This is not limited to first time preventive medicine patients.</p>
10	<p>Could you tell me if a patient has to wait a year and one day for their next annual wellness visit, or can it be done 11 months after the first one? We have a lot of snow birds that may have had the annual wellness visit done up north, and are not sure if they had it or not, so are we allowed to have them sign an ABN if they are not sure if they have had it?</p>	<p>The Annual Wellness Visit can be performed annually, meaning after full 11 months have passed since last AWV.</p> <p>Providers have different options for accessing Initial Preventive Physical Exam (IPPE) and Annual Wellness Visit (AWV) eligibility information depending on the jurisdiction in which they reside. For example, Medicare Administrative Contractors (MACs) who have Internet portals provide the information through the eligibility screens of the portals. The information is also provided through the HIPAA Eligibility Transaction System (HETS), as well as HETS User Interface, or the Common Working File (CWF), through the provider call center Interactive Voice Responses (IVRs). CMS suggests that providers check with their MAC to see what options are available to check eligibility for the AWV, as well as other preventive services.</p> <p>If a beneficiary would like to receive an Annual Wellness Visit before the allowable time under Medicare payment guidelines, providers can issue an ABN to further make the beneficiary aware that Medicare may not pay for the service.</p>
12	<p>When will there be an MLN matters for new preventive services:</p> <ul style="list-style-type: none"> • Screening for sexually transmitted infections (STIs) and intensive behavioral counseling to prevent STIs. • Intensive behavioral therapy for obesity 	<p>To ensure you have the most accurate coding and claims processing information please reference the claims processing instructions, along with the MLNMatters articles, released for each of the new prevention NCDs. Currently available online are the instructions for Screening for Depression in Adults, Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse, and Intensive Behavioral Therapy for Cardiovascular Disease. Instructions for the other two issues, Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to prevent (STIs), and Intensive Behavioral Therapy for Obesity will be released in the coming months. Below are links to the instructions and MLN Matters articles for the first three NCDs:</p> <p>Screening for Depression in Adults - Claims processing instructions: http://www.cms.gov/transmittals/downloads/R2359CP.pdf MLN Matters article: MM7637 <i>Screening for Depression</i> http://www.cms.gov/MLNMattersArticles/Downloads/MM7637.pdf</p> <p>Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse – Claims processing instructions: http://www.cms.gov/transmittals/downloads/R2358CP.pdf</p>

		<p>MLNMatters article: MM7633 http://www.cms.gov/MLNMattersArticles/Downloads/MM7633.pdf</p> <p>Intensive Behavioral Therapy for Cardiovascular Disease – Claims processing instructions: http://www.cms.gov/transmittals/downloads/R2357CP.pdf MLNMatters article: MM7636 https://www.cms.gov/MLNMattersArticles/downloads/MM7636.pdf</p> <p>Please periodically visit the transmittals website (http://www.cms.gov/Transmittals/01_Overview.asp) for the instructions specific to Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to prevent (STIs) and Intensive Behavioral Therapy for Obesity.</p>
13	<p>We have found no information on how to bill these services. No CPT recommendations, no diagnosis requirements. Nothing since this evolved. Please give us billing instructions for these new services.</p>	<p>For more information about CPT codes and billing instructions please click on the following link: http://www.cms.gov/MLNMattersArticles/downloads/MM7672.pdf</p>
14	<p>Can a beneficiary receive more than one preventative service at one appointment? For example: a Wellness visit, pelvic, and pap tests</p>	<p>The HCPCS codes for the first AWW service (G0438) and subsequent AWW services (G0439) do not include other preventive services that are paid separately by Medicare. Such services can be provided on the same day as the AWW, but they should be identified separately using the appropriate HCPCS/CPT codes. When practitioners perform preventive services in addition to an AWW visit, billing and payment edits will continue to apply for the additional services.</p>
15	<p>Can you please restate the effective dates for the new preventive services?</p>	<p>The effective dates are included below for each of the new preventive services covered under Medicare Part B.</p> <p>Screening for Depression in Adults: October 14, 2011</p> <p>Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse: October 14, 2011</p> <p>Intensive Behavioral Therapy for Cardiovascular Disease: November 8, 2011</p> <p>Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to prevent (STIs): November 8, 2011</p> <p>Intensive Behavioral Therapy for Obesity: November 29, 2011</p>